

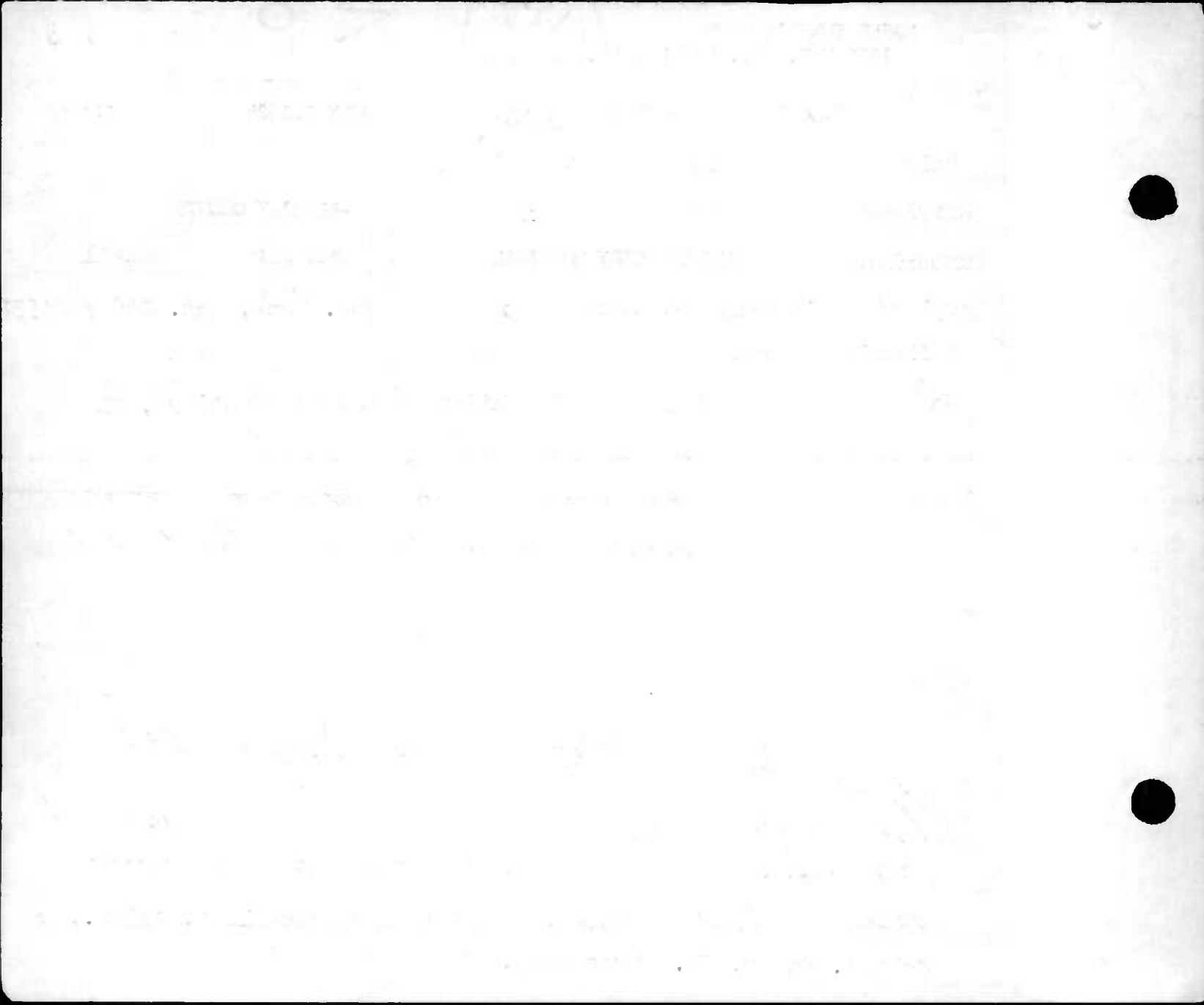
HAFER FUNERAL HOME 1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 7 7 3 3			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST GURNEY AUGUSTUS BEEMAN				MONTH DAY YEAR JULY 1, 1984				10:20P _M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		MONTH DAY YEAR 10 15 11		72 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA						ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Manager		Retail			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Frostburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Fbg. Hgts. Apt. 216 / 21532			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Philander Beeman				FIRST MIDDLE LAST Emma Croft							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		215 10 4483		Philander Beeman		Rte 1, Box 95 Frostburg, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the pharynx</i>										3 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Advanced Chronic Obstructive Pulm Disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1 1984</i> to <i>July 1 1984</i> , that (I) (we) last saw the deceased alive on <i>July 1 1984</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>Chang Oh, M.D.</i>				MD						<i>July 2 84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
CHANG OH, M.D.				48 TARN TERRACE FROSTBURG, MD. 21532							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		7/5/84		Sunset Memorial Park		Cumberland, Alleg., MD					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Jr. Frostburg, MD				JUL 5 1984		<i>Davidson-Randell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17734					
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL CALHOUN BENNETT										MONTH DAY YEAR <input checked="" type="checkbox"/> 7 6 1984		2b. HOUR 6: P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 31 98		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 6 1984		2d. HOUR 11: P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bedford Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker Textile/Fiber				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route #3 / 21502					
14. FATHER'S NAME FIRST MIDDLE LAST George Milton Bennett						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Wilson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214 07 0561		17. INFORMANT ADDRESS Allen C. Bennett Cumberland, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Francisco Reyes</u>				TITLE (SPECIFY) <u>Deputy</u> M.D.				MEDICAL EXAMINER				DATE SIGNED <u>7/6/84</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Francisco Reyes</u>				ADDRESS <u>900 Seton Dr. Cumberland, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/9/84		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Artemas, Bedford, PA					
24. FUNERAL DIRECTOR NAME <u>William G. Kight</u> ADDRESS <u>Cumberland, MD</u>						25a. DATE RECD. BY REGISTRAR <u>JUL 11 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Jule Hudson</u>							



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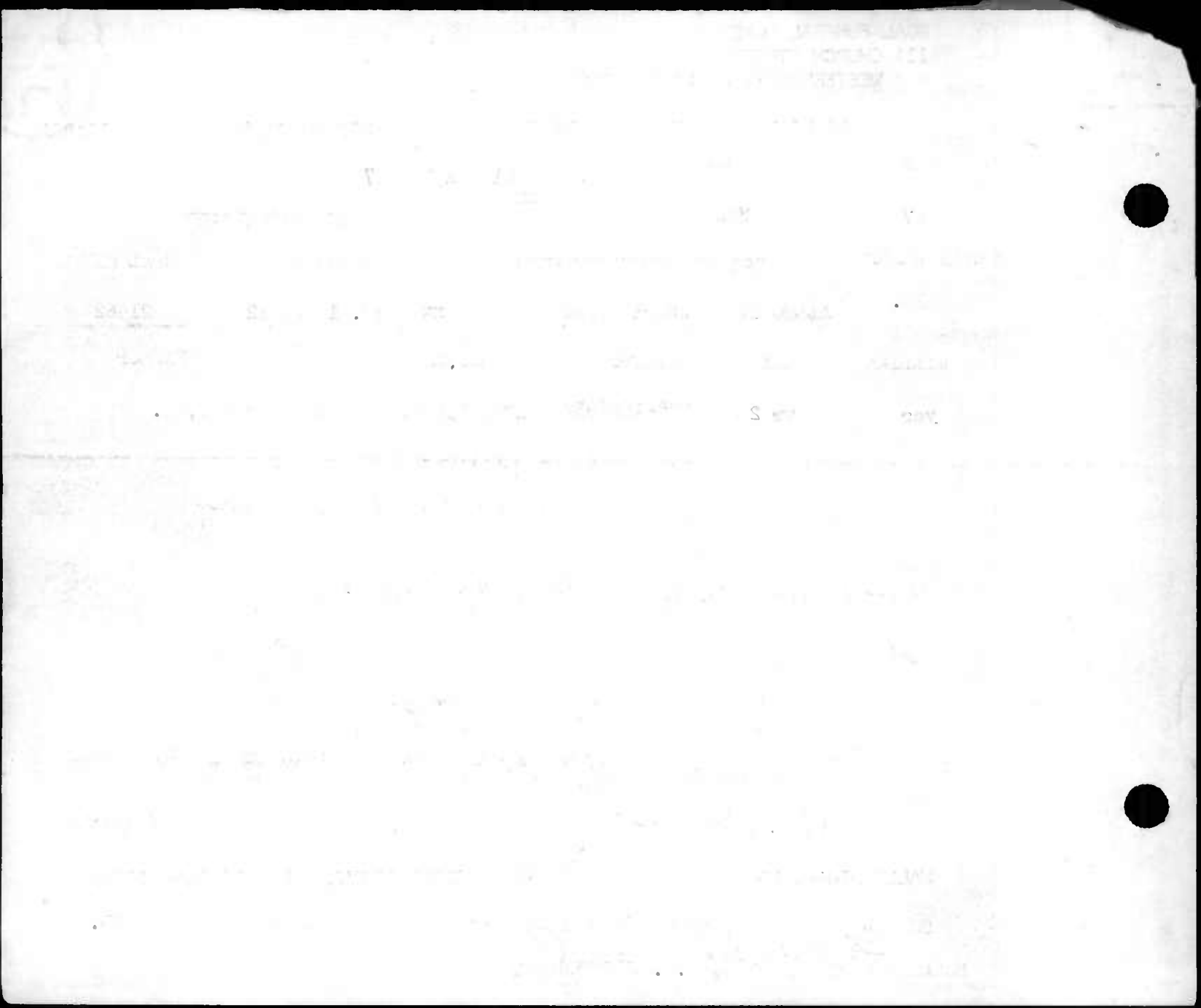
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOAL FUNERAL HOME FOR 111 CHURCH STREET STATE REGISTRAR WESTERNPORT, MD XXXXX 21562				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				84 17735 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM RAY BISHOP						2a. DATE OF DEATH MONTH DAY YEAR JULY 3, 1984				2b. HOUR 11:05AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 21 1926		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS MIN. 57		7. UNDER 1 YEAR MONTHS DAYS MIN. 0 0 0		8. UNDER 74 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAC RED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY COAL MINES			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 1 BOX 12 21562			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM RAY BISHOP				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL BISHOP							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes ww 2		16b. SOCIAL SECURITY NO. 220-16-6932		17. INFORMANT ANNA BISHOP		ADDRESS WESTERNPORT, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 11a. <u>Heart Failure; paralytic ileus; "peritonitis"</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 13</u> 19 <u>84</u> to <u>July 3</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. H. H. M. D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/4/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLY HIJAB, MD						22e. ADDRESS 909-A SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/6/84		23c. NAME OF CEMETERY OR CREMATORY BLOOMINGTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BLOOMINGTON GARRETT MD.					
24. FUNERAL DIRECTOR NAME ADDRESS BOALS FUNERAL SERVICE, P.A. WESTERNPORT						25a. DATE REC'D. BY REGISTRAR JUL 10 1984		25b. REGISTRAR'S SIGNATURE <u>Ed. K. ...</u>			



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7 4 1 7 7 3 6	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cleo Mildred Bowman		2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-1-1984	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-28-1914	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 69 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	
10. CITY OR TOWN OF DEATH Danville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 3, Danville, Md.	
13a. STATE Maryland		13b. COUNTY Allegany	
14. FATHER'S NAME FIRST MIDDLE LAST Harrison W. Flanagan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jane Ketterman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-07-6543	
17. INFORMANT Mr. Albert R. Bowman		ADDRESS 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: ARTERIOSCLEROTIC HEART DISEASE IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? m	
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Giovanni Mastrangelo M.D.		TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.		ADDRESS 900 Seton Drive, Cumberland, Md. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-5-1984	
23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Danville, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli ADDRESS		25a. DATE REC'D. BY REGISTRAR 5/1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodella	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 1 3 7

1 - FOR
STATE
REGISTRAR

REG. NO.

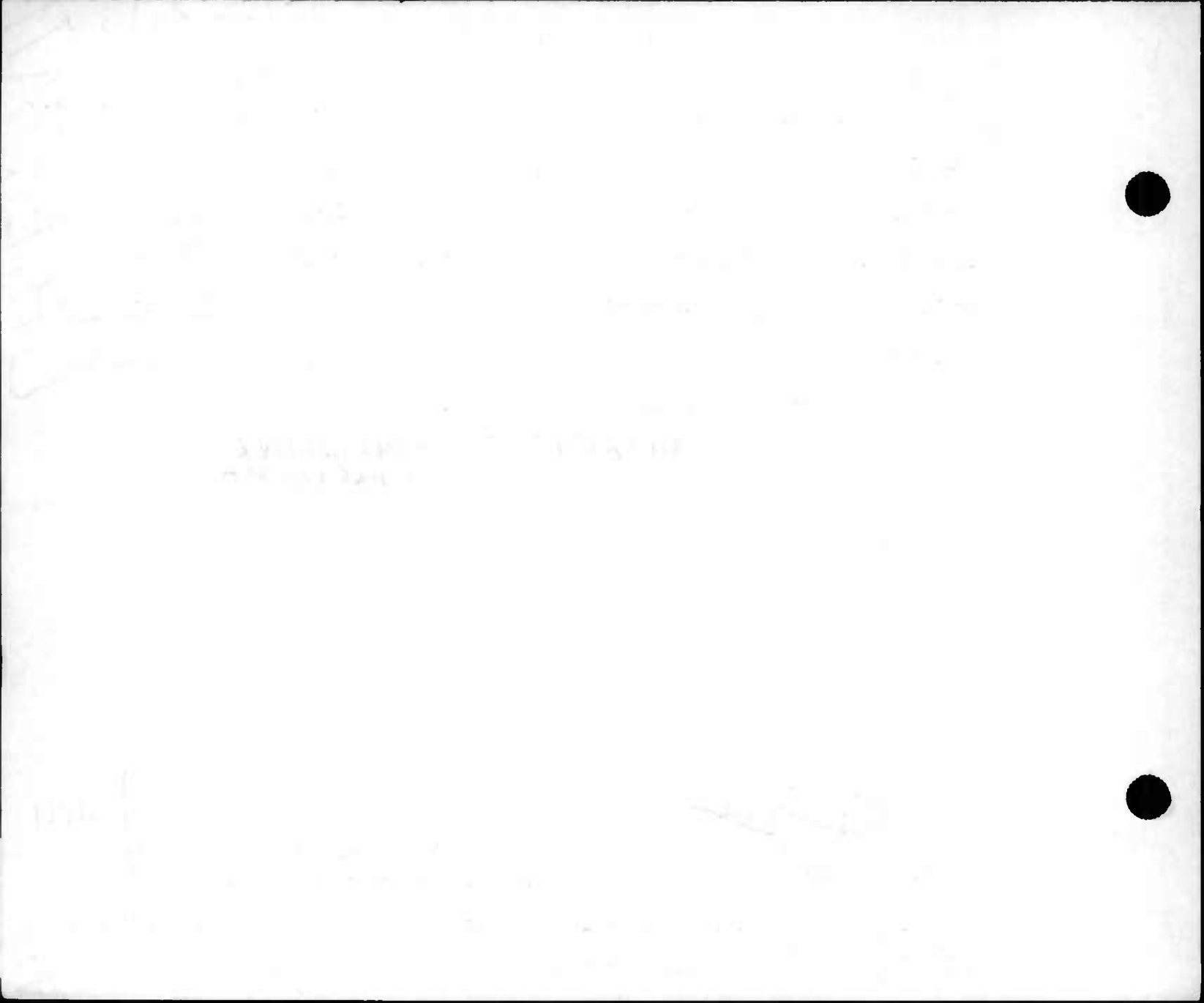
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
VIRGINIA CATHERINE BOWSER				JULY 29, 1984				7:12 A.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White	Sept. 7, 1914		69		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Allegany County, MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND	MEMORIAL HOSPITAL & MEDICAL CENTER		Farmer		Farming				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Garrett		Grantsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Box 52, 21536	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Elias McClintock		Clara Bertha Ringer		No		159-36-3656		Ralph J. Bowser, Grantsville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC GALLBLADDER CARCINOMA				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not see the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Dr. Qamar Zaman		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/30/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS					
Dr. Qamar Zaman		Memorial Hospital Medical Building		Cumberland, Maryland		21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Aug. 1, 1984		Addison Cemetery		Addison, Somerset, Penna.			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
D. L. Newman		Grantsville, MD		AUG 3 1984		J. L. Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



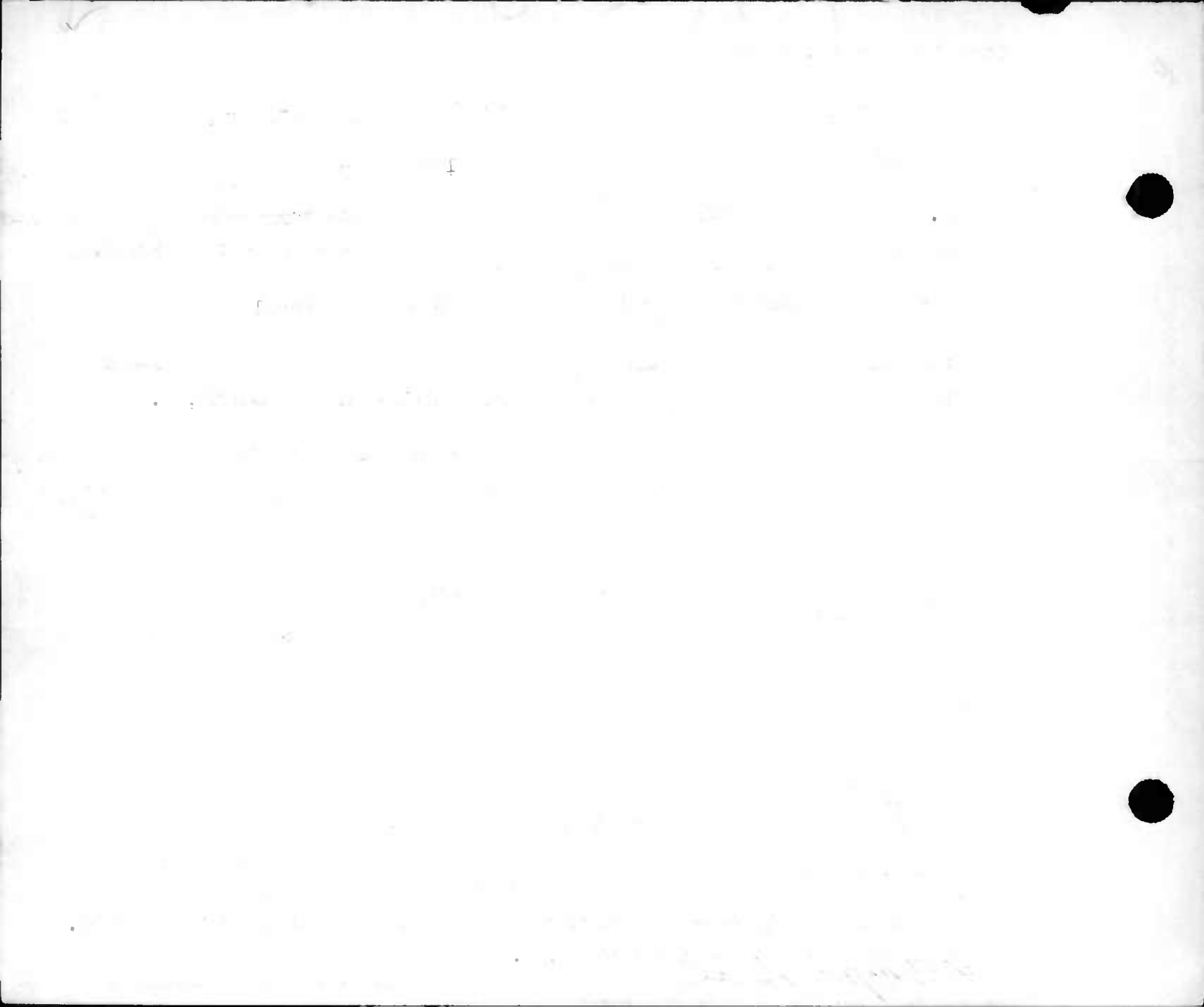
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 84 17738									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILLARY M BROADWATER					2a. DATE OF DEATH MONTH DAY YEAR July 13, 1984		2b. HOUR A M 10:32 A M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 8 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (IF DECEASED WAS NOT WORKING AT TIME OF DEATH) CRANE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY PAPER MILL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY ALLEGANY 13c. CITY OR TOWN BARTON					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural 21521		
14. FATHER'S NAME FIRST MIDDLE LAST KENNETH BROADWATER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA WILAND						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-01-6696		17. INFORMANT RUBY BROADWATER		ADDRESS BARTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Septicemia Shock. DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia due to Proteus. DUE TO, OR AS A CONSEQUENCE OF (c) 4 days.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile Hypotension - Pericarditis, by EKG.									
19a. DATE OF OPERATION 7/9/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Senile Hypotension - Pericarditis, by EKG.			7b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE M. Saheta MD.						DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Saheta				22e. ADDRESS Memorial Hospital & Medical Center, Inc. Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/16/84		23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE MOSCOW MILLS ALLEGANY MD.			
24. FUNERAL DIRECTOR BOALS FUNERAL SERVICE WESTERNPORT, MD.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JUL 17 1984 John Swinton Registrar			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

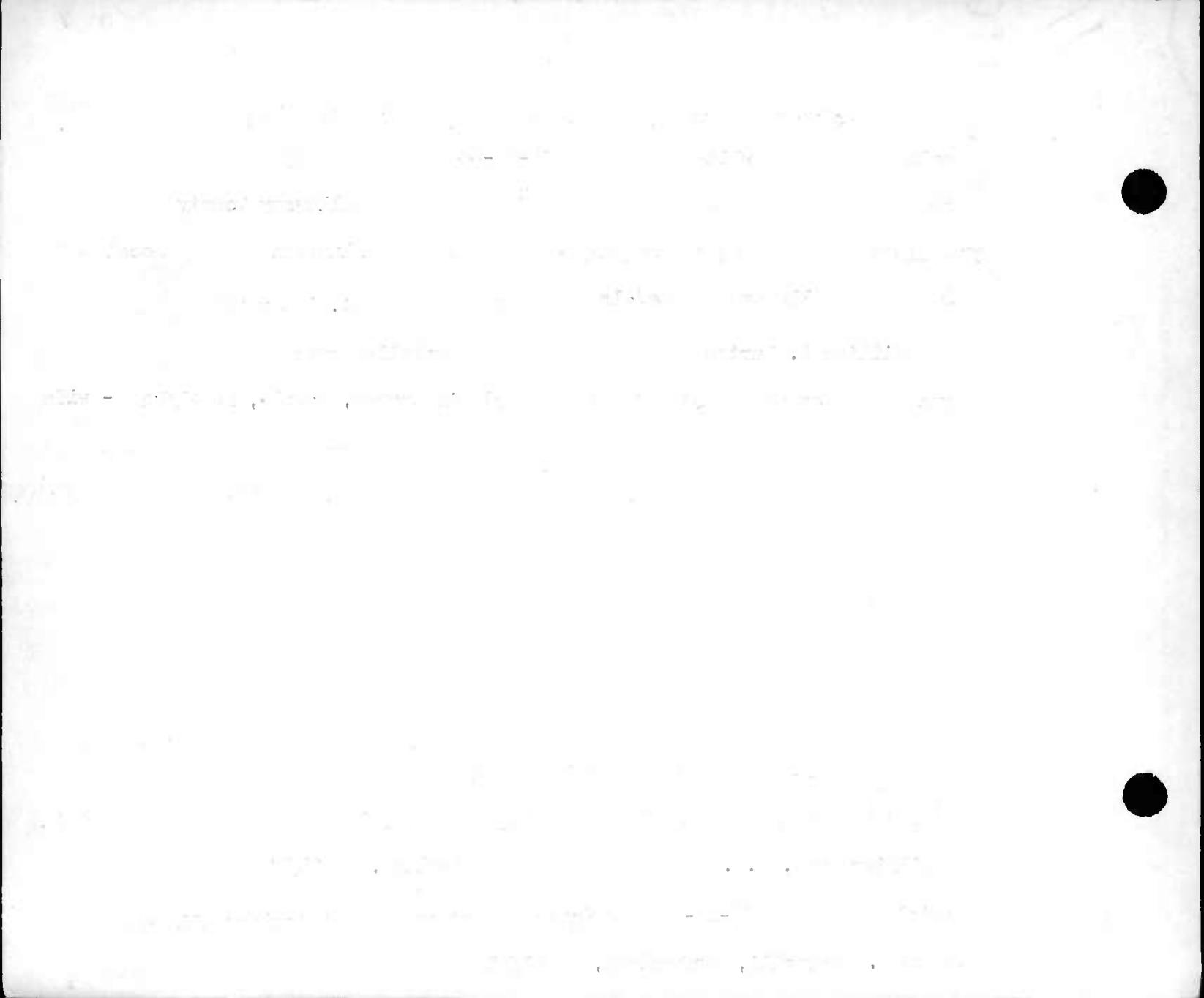
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND JOSEPH BURTON, SR.			2a. DATE OF DEATH MONTH DAY YEAR JULY 24, 1984		2b. HOUR MIN. 12:25		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07-24-84 1930		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 53	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumbers		12b. KIND OF BUSINESS OR INDUSTRY Local 489	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William L. Burton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Crowe		13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 208 81502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 213-24-6212		17. INFORMANT ADDRESS Deloris Burton, LaVale, MD 21502 - wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CARCINOMA OF LUNG						16 months	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if) this hospital attended the deceased from April 19 83 to July 24 19 84, that (if) (we) last saw the deceased alive on July 20 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) were the last to see the deceased.							
22b. SIGNATURE William Lamm				DEGREE MD		22c. DATE SIGNED 7/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Lamm, M.D.				22e. ADDRESS Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07-27-84		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR JUL 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8417740

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR		4:30		M	
SARA		Rebecca		BUTLER				JULY 19, 1984															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS		DAYS		HOURS		MIN.					
Female		White		April 29 1908		76																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
VA		USA				BALTIMORE CITY																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
CUMBERLAND		MEMORIAL HOSPITAL & MEDICAL CENTER		Housewife																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE															
MD		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		527 Lowell Ave. 21502															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																					
John		Thomas		Lillie		Reed																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
NO		218-68-4729		Joseph Butler		222 Martling Ave., Tarrytown, NY 10591																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF																	
		CHF		ASCVD																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Pneumonia		malnutrition																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY?		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
22a. I certify that (he) (his) (her) (her) attended the deceased from 7-19 1984 to 7-19 1984, that (he) (she) (we) lost saw the deceased alive on 7-19 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) sew the body after death.																							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED																			
Dr. Anthony J. Bollino, Jr.		M.D.		7-19-84																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. CITY OR TOWN		22g. COUNTY		22h. STATE															
DR. ANTHONY J. BOLLINO, JR.		955 FREDERICK ST.		CUMBERLAND, MARYLAND		21502																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE													
Burial		7/21/84		Ivy Hill Cemetery		Upperville Fauquier		VA															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Silcox-Merritt F.H.		404 Decatur St., Cumb., MD		JUL 23 1984		[Signature]																	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17741

FOR
 1 - STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PERRY FRANCIS CESSNA			2a. DATE OF DEATH MONTH DAY YEAR JULY 3, 1984		2b. HOUR MIN. 1:02
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 04/29/03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carman	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Allegany	13c. CITY OR TOWN Mt. Savage	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 1, Box 128F/ 21545	
14. FATHER'S NAME FIRST MIDDLE LAST Perry Francis Cessna, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Cameron		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATE) no		16b. SOCIAL SECURITY NO. 214-14-7538		17. INFORMANT ADDRESS Thomas L. Cessna, R D 1, Hyndman, Pa. 15545	
18. CAUSE OF DEATH (Enter only one cause per line. Do not include (a) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF, (b) Uremia, Infectious CHF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) CAD, ASVD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) received the deceased from (a) July 3, 1984 to (b) July 3, 1984 that (1) (we) last saw the deceased alive on (a) July 3, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) not see the body after death.					
22b. SIGNATURE Dr. Terry Williams		DEGREE		22c. DATE SIGNED 7-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS		22e. ADDRESS MEMORIAL HOSPITAL & MEDICAL CENTER MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/5/84	23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale, Allegany, Maryland	
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler		ADDRESS Hyndman, Pa. 15545		25a. DATE REC'D. BY REGISTRAR JUL 9 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

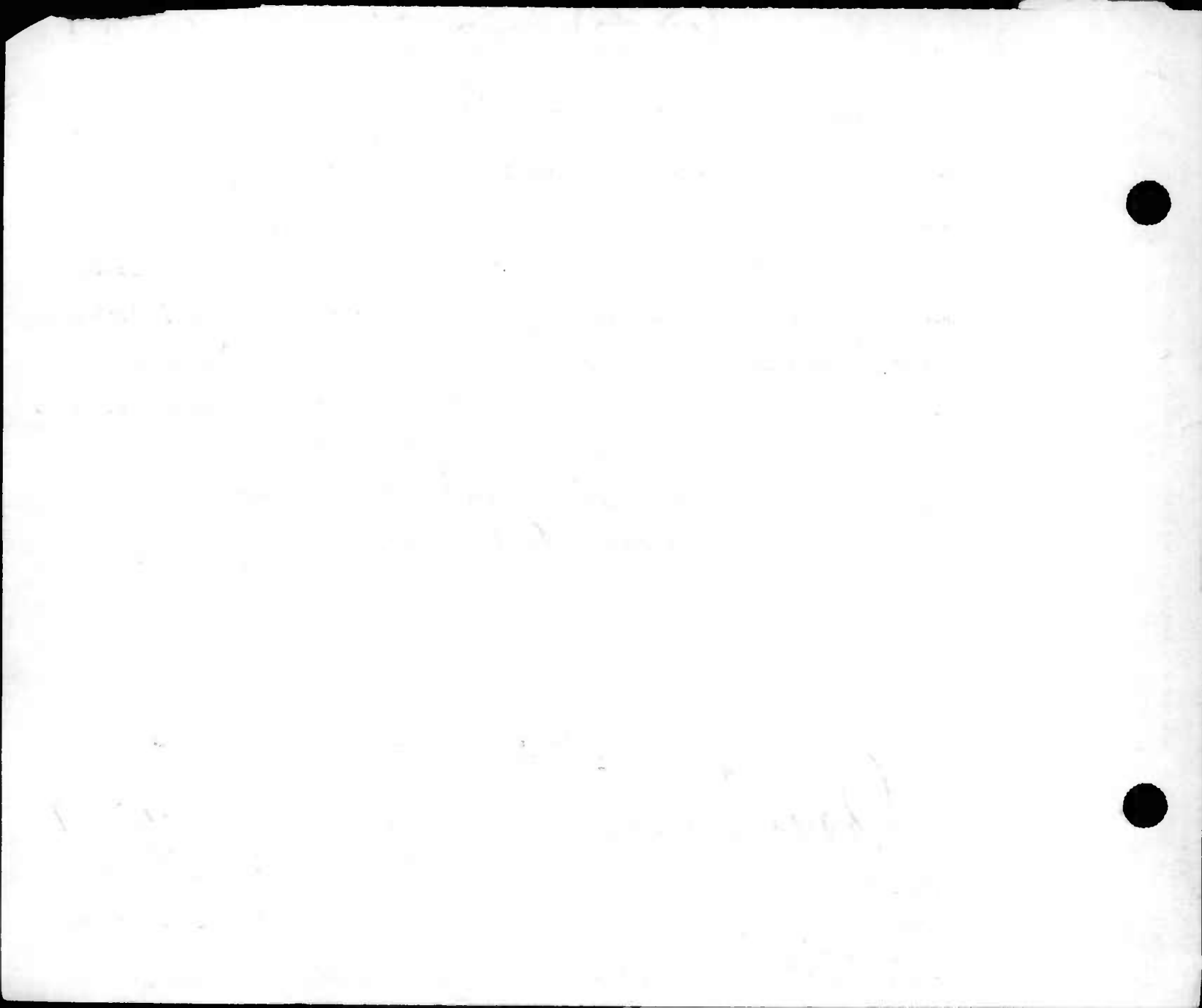
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8417742			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR 7:02 P. M.			
ROY THOMAS CHARLTON				JULY 1, 1984			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Welder		12b. KIND OF BUSINESS OR INDUSTRY Own	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN CUMBERLAND		13e. STREET ADDRESS Baltimore Pike 21502	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Arthur C. Charlton				Mary M. Boswell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 220-07-6604		17. INFORMANT ADDRESS Robert L. Charlton, Cumberland, Md. Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocardial Infarction</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 7/1/84, that (I) (we) lost saw the deceased alive on 7/1/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED 7/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. FISCUS				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-2-1984		23c. NAME OF CEMETERY OR CREMATORY Rosedale Funeral Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg, W. Va.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli				25a. DATE REC'D. BY REGISTRAR 5-1-84		25b. REGISTRAR'S SIGNATURE <i>Lia Anderson-Randall</i>	



White

USA

West Virginia

et al.

et al.

et al.

et al.

et al.

et al.

et al.

et al.

et al.

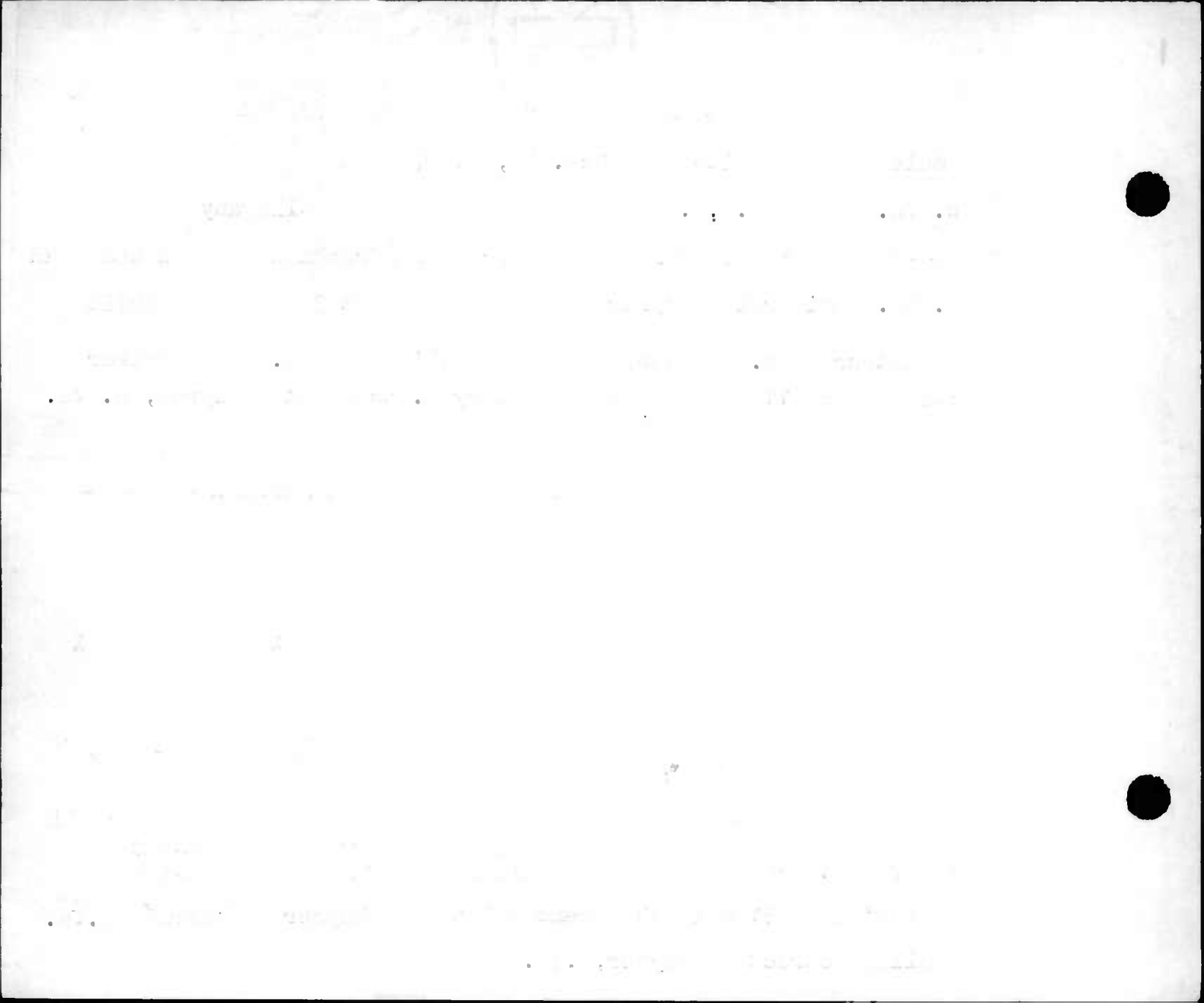
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES EDWARD COOK			2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1984		2b. HOUR 8:05 P. M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 24 HRS. HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman		12b. KIND OF BUSINESS OR INDUSTRY B and O RR			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 3 26726		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur T. Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mahalia C. Walker			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW 11					
16b. SOCIAL SECURITY NO. 236-14-5886			17. INFORMANT ADDRESS Henry L. Cook Rt 3 Keyser, W. Va.								
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Resp. Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe COPD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 7/27/84 to 7/27/84 , that (we) last saw the deceased alive on 7/27/84 , and that injury (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.											
22b. SIGNATURE Skinner			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/30/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JUDY A. STONE			22e. LOCATION MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 31 July 84		23c. NAME OF CEMETERY OR CREMATORY Queens Point		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.				
24. FUNERAL DIRECTOR NAME Allen Rotruck			ADDRESS Keyser, W. VA.			25a. DATE REC'D. BY REGISTRAR AUG 6 - 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



SCARPELLI FUNERAL HOME
STATE OF MARYLAND
1. FOR 108 VIRGINIA AVENUE
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR CUMBERLAND, MD. 21502
CERTIFICATE OF DEATH

8 4 1 7 7 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICHOLAS PETER COSENZA			2a. DATE OF DEATH MONTH DAY YEAR JUNE 30, 1984		2b. HOUR 6:45P M
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02-25-17	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver	12b. KIND OF BUSINESS OR INDUSTRY paper box Co.		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 13111 Bowling St. Bowling Green 21502
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Cosenza			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Abbott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) War II	17. INFORMANT ADDRESS Filomena Caccavano - wife Cosenza			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Anoxic Insult</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>		18d <u>18d</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Atherosclerosis</u>		10 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (any) (oid) (did not) view the body after death.

23a. SIGNATURE <u>V. Mazzocco MD</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-2-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. V. EUGENE MAZZOCCO		22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 07-04-84	23c. NAME OF CEMETERY OR CREMATORY Rocky Gap Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE 9 1984	25b. BY REGISTRAR 25c. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rondella</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200-1000

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

Dear Sir:
Enclosed for you are 10 copies of the report of the
Joint Commission on the Organization of the
Department of Agriculture, dated 10/27/63.

Sincerely,
[Signature]

2-5-64
[Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 4 5

1 - FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE ALICE CORNELIUS			2a. DATE OF DEATH MONTH DAY YEAR July 1, 1984		2b. HOUR a 2:20 M						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Wkr.		12b. KIND OF BUSINESS OR INDUSTRY Brass Works			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 235 Paca St. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Apslon H. Nelson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida F. Clayton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 376-05-9561		17. INFORMANT ADDRESS John Roy, Rt. 3 Box 194, Clearville, Pa. 15535							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Intractable Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

COPD CAD

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that Dr. (this hospital) attended the deceased from saw the deceased alive on 6/10/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. S. Nathan		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		22e. ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/5/84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.	
24. FUNERAL DIRECTOR NAME George-Upchurch Fun'l. Home, P.A. 202 Greene St. Cumberland, Md. 21502				25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE JUL 6 1984 John Davidson			

BP _____

DHMH-16 25M
 (VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3
A

International Year for

1948-1949

1948/1949
1948/1949
1948/1949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albert F. Cutter			2a. DATE OF DEATH MONTH DAY YEAR July 5, 1984		2b. HOUR 8:00 PM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 18, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. UNDER 1 YEAR MONTHS DAYS 59		8. UNDER 24 HRS. HOURS MIN. 59	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 W. Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY College			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 203 W. Main St. 21532			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Cutter Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Plummer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-18-3400		17. INFORMANT ADDRESS Mary E. Cutter, Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis abdominal DUE TO, OR AS A CONSEQUENCE OF (b) pan cancer rectum DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION 1981/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer rectum				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 1980 , 19____, to July 5, 1984 , that (2) (we) last saw the deceased alive on July 3, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
22b. SIGNATURE Thomas F. Lewis M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/9/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Lewis, M.D.						22e. ADDRESS Mem. Hosp. Med. Bldg., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg, Allegany, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md. 21532						25a. DATE REC'D. BY REGISTRAR JUL 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			



Albert	F.	Outter	July 2, 1934	3:00 PM
Male	White	August 18, 1934	39	
Maryland	U.S.A.	I	Allegany	
Frontier	303 W. Main Street	303 W. Main Street	303 W. Main Street	
Maryland	Allegany	Frontier	X	303 W. Main Street
William H.	Outter Dr.	Boeing	Frontier	
No	21-18-3400	May 2, Outter, gave to the		

Handwritten signature and notes, mostly illegible.

Thomas F. Lewis, M.D.
Men. Hosp. Bldg., Cumberland, Md.
Burial July 2, 1934, Frontier Memorial Co., Frontier, Md.
Frontier Funeral Home, Frontier, Md.

31

GEORGE & UPCHURCH FUNERAL HOME
202 GREEN STREET

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8417741

1 - FOR
STATE
REGISTRAR

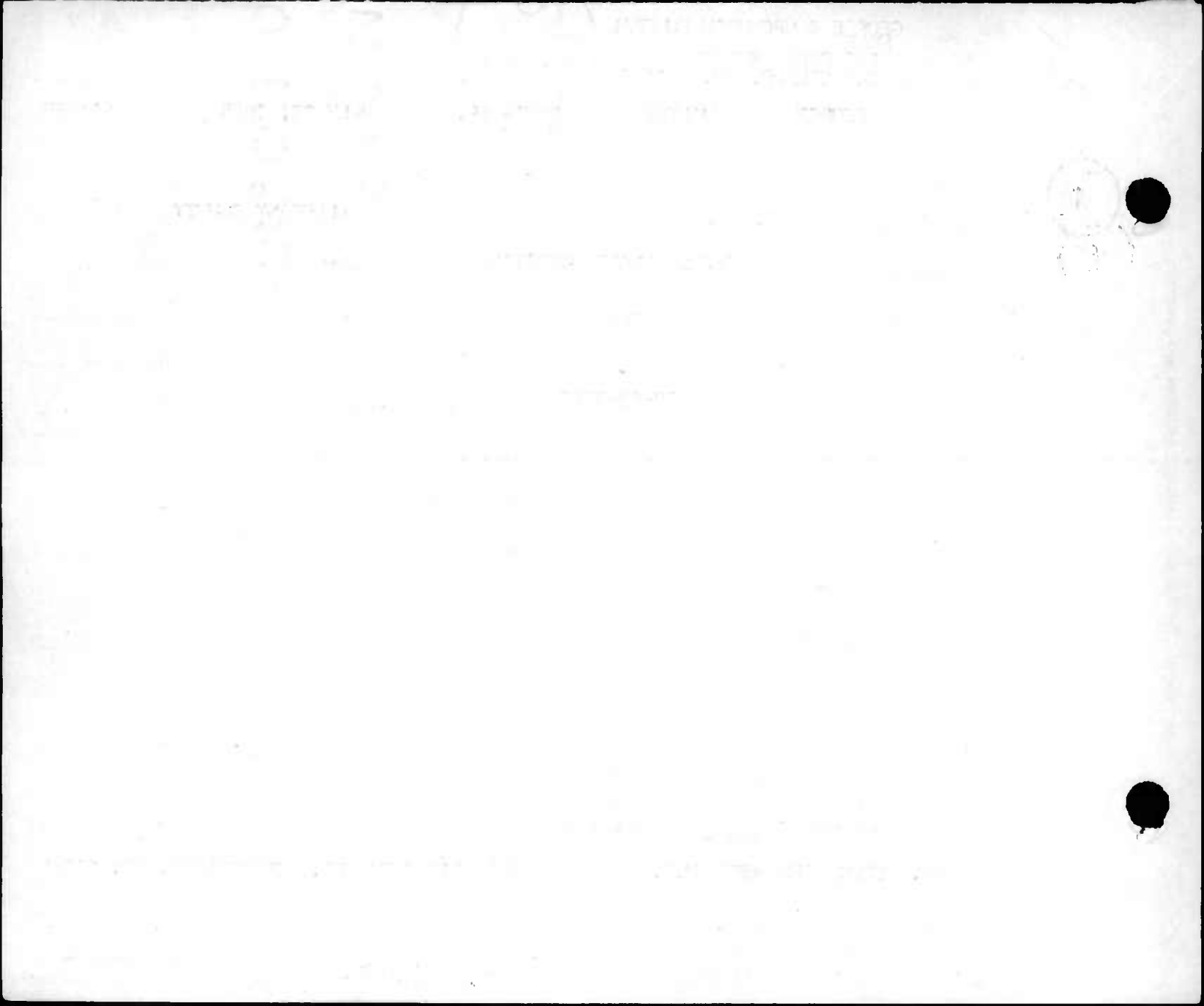
202 GREEN STREET
CUMBERLAND, MD. 21502

CERTIFICATE OF DEATH

REG. NO

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GEORGE		WALTER		DAVIS SR.	
JULY 23, 1984		21:25P _M			
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		February 26, 1910	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
West Virginia		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland		SACRED HEART HOSPITAL		Miner	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland		Allegany Rawlings		P.O. Box 226 / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES	
Samuel R. Davis		Catherine -- Lipscomb		No --	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>	
232-09-3383		Olive C. Davis-Address same as #13 ABOVE.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 80</u> to <u>July 28 84</u> , that (I) (we) last saw the deceased alive on <u>July 28 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.		22b. SIGNATURE <u>Bruce Behounek</u> DEGREE <u>MD</u>		22c. DATE SIGNED <u>July 28 '84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. PHYSICIAN'S NAME (TYPE OR PRINT)	
DR. BRUCE BEHOUNEK, M.D.		BMG, 912 SETON DR., CUMBERLAND, MD. 21502		22f. PHYSICIAN'S NAME (TYPE OR PRINT)	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-26-84		Rose Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Thomas-Tucker Co.-West Va.		JUL 30 1984		P. Davidson-Randall	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502		JUL 30 1984		P. Davidson-Randall	

MEDICAL CERTIFICATION



DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Harold William Dixon Sr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-2 1984 2b. HOUR MIN. 8¹⁵a 30m											
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS 72		IF UNDER 24 HRS. HOURS MIN. 72		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR July 2 1984									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD									
10. CITY OR TOWN OF DEATH Oldtown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 5, Oldtown, Md.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Policeman				12b. KIND OF BUSINESS OR INDUSTRY D.C. Police Dept.					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 5		21556											
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Dixon										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude (Scalf) Scalf											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Peace Time				16c. SOCIAL SECURITY NO. 578-50-6450				17. INFORMANT ADDRESS Mrs. Annie Dixon, Oldtown, Md. Wife									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Pulmonary Embolism. (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Francisco Reyes										TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 7-2-1984							
EXAMINER'S NAME (TYPE OR PRINT) Dr. Francisco Reyes M.D.										ADDRESS Sacred Heart Hospital, Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-5-84		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.											
24. FUNERAL DIRECTOR NAME James F. Scarpelli										ADDRESS Cumberland, Md. 21501		25a. DATE REC'D. BY REGISTRAR 9 1984		25b. REGISTRAR'S SIGNATURE Juhia Davidson-Rendell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the hospital death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 / 4 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE RAYMOND DREW			2a. DATE OF DEATH MONTH DAY YEAR July 15, 1984		2b. HOUR: 5:15 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bull Dozer Operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Drew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Thomas		13e. STREET ADDRESS / ZIP CODE Rt.1, Box 190 21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2		17. INFORMANT Mrs. Jean Jenkins, Laurel, Md. 20707		15951 ADDRESS Dorset Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe COPD DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: Cor pulmonale, CHF							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 7-6-84 to 7-15-84 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-15-84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above; (2) <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE Shan Nathan		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Shan Nathan		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/17/84		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory Smithsburg, Wash., Md.		23d. LOCATION CITY OR TOWN COUNTY	
24. FUNERAL DIRECTOR NAME Drst Funeral Home,		ADDRESS Frostburg, Md.		25a. DATE REC'D. BY REGISTRAR JUL 25 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Eilbeck		2a. DATE OF DEATH MONTH DAY YEAR July 9, 1984		2b. HOUR 10:10 P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 15 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Lonaconing		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 A Water Station Run		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Ser. Station	
12b. KIND OF BUSINESS OR INDUSTRY Gas		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 1 A Water Station Run	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholson Eilbeck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Perry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 214-07-0102		17. INFORMANT ADDRESS Mrs. Isabel Moses, Lonaconing, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive pulmonary disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic obstructive pulmonary disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 8 1984 to 5 19 84 , that (I) (we) lost saw the deceased alive on 3 12 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald E. Manger		DEGREE		22c. DATE SIGNED 10 Jul 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Manger		22e. ADDRESS 65 JACKSON ST LONA CONING			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	
23d. LOCATION Frostburg Allegany Md					
24. FUNERAL DIRECTOR George H. Eichenhorn		25a. DATE REC'D. BY REGISTRAR JUL 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8417751			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA BLANCHE EVANS				2b. HOUR 7:10 p.m.			
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 23, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Textile	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Charles W. O'Brian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Milenda Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-6677		17 INFORMANT ADDRESS Mr. Clarence Evans, Cumberland, Md. Son			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/30 19 84, to 7/1/84 19 84, that (I) (we) lost saw the deceased alive on 7/1 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE T. Elder MD				DEGREE MD		22c. DATE SIGNED 7/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T. ELDER				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-3-1984		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Md.	
24 FUNERAL DIRECTOR NAME James F. Scarpelli				25a. DATE REC'D. BY REGISTRAR JUL 5 1984			
ADDRESS Cumberland, Md. 21504				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



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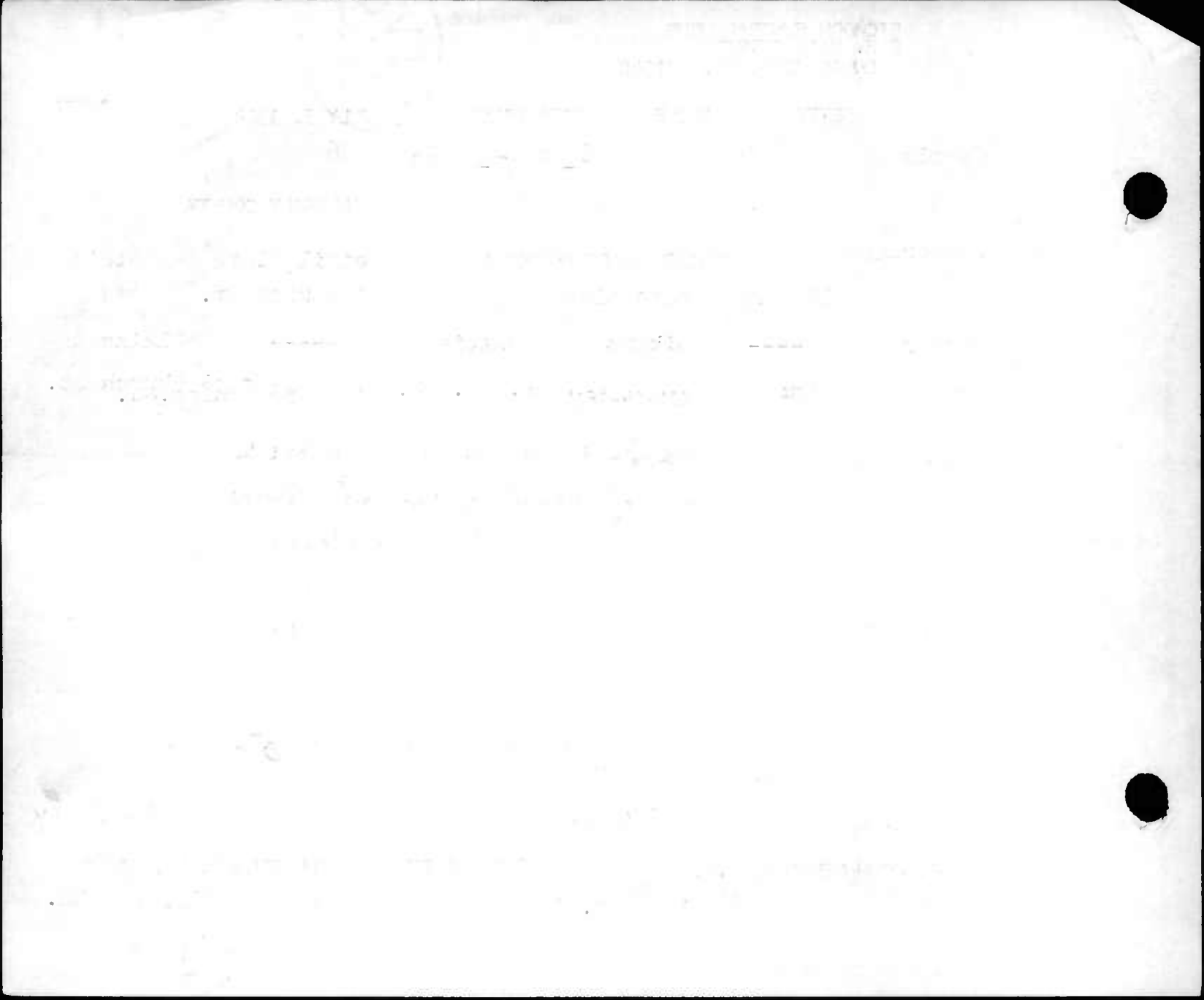
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EICHORN FUNERAL HOME 8 E. MAIN STREET LONA CONING, MD. 21540				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
BETTY IRENE FAZENBAKER				JULY 5, 1984			
3. SEX				4. RACE			
Female				White			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
March 17 - 1928				56			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Md				USA			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
				ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Retail Clerk				Clothing			
13a. STATE				13b. COUNTY			
Md				Allegany			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Lonaconing				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Edgar				Nettie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
None				212-24-1614			
17. INFORMANT				ADDRESS			
Mr. Wm. H. Fazenbaker				43 Church St. Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Respiratory failure & shock</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>ca of heart & pleural effusion</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>liver metastases</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>7-2</u> 19 <u>84</u> to <u>7-5</u> 19 <u>84</u> , that (I) (we) last saw the deceased <u>alive on</u> <u>7-4</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) <u>wait</u> the body after death.							
22a. SIGNATURE				22c. DATE SIGNED			
<u>John Mehan</u>				7-5-84			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR. JOHN MEHANNA, M.D.				909-B SETON DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				July 7, 1984			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Mt. View Cemetery				Moscow Allegany Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
George H. Eichhorn				10 1984			
Eichhorn Funeral Home 8 E MAIN ST, 21502				25b. REGISTRAR'S SIGNATURE			
				Chia Davidson-Hendall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ruth Elizabeth Flanagan										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 26 84		2b. HOUR 11:45	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1904		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 80		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 26 84		2d. HOUR 11:55a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Frostburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Rawlings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 3		21567			
14. FATHER'S NAME FIRST MIDDLE LAST Elijah Huffman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Ann Kieling									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217 10 4793				17. INFORMANT ADDRESS Doc G. Flanagan RD 3 Rawlings, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>				TITLE (SPECIFY) DEPUTY				MEDICAL EXAMINER				DATE SIGNED 7-26-84	
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.				ADDRESS 900 Seton Drive, Cumberland, MD21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 28 July 84		23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rawlings Allegany Md.			
24. FUNERAL DIRECTOR NAME Allen Rotruck				ADDRESS Keyser, W.VA.				DATE REC'D. BY REGISTRAR JUL 31 1984 REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



Alfred White April 2, 1904 20

W. Va. U.S.A. X

Postmaster Prospector Community Assoc. Home

Ed. Higgins Sawlins X

Lillian Hoffman Julia Ann Higgins

217 10 1123 Loc. C. Sawlins Rd 3 Sawlins, W. Va.

Allen Cotton Agent, W. Va.
Burlington 20 July 20 1904 Community Assoc.

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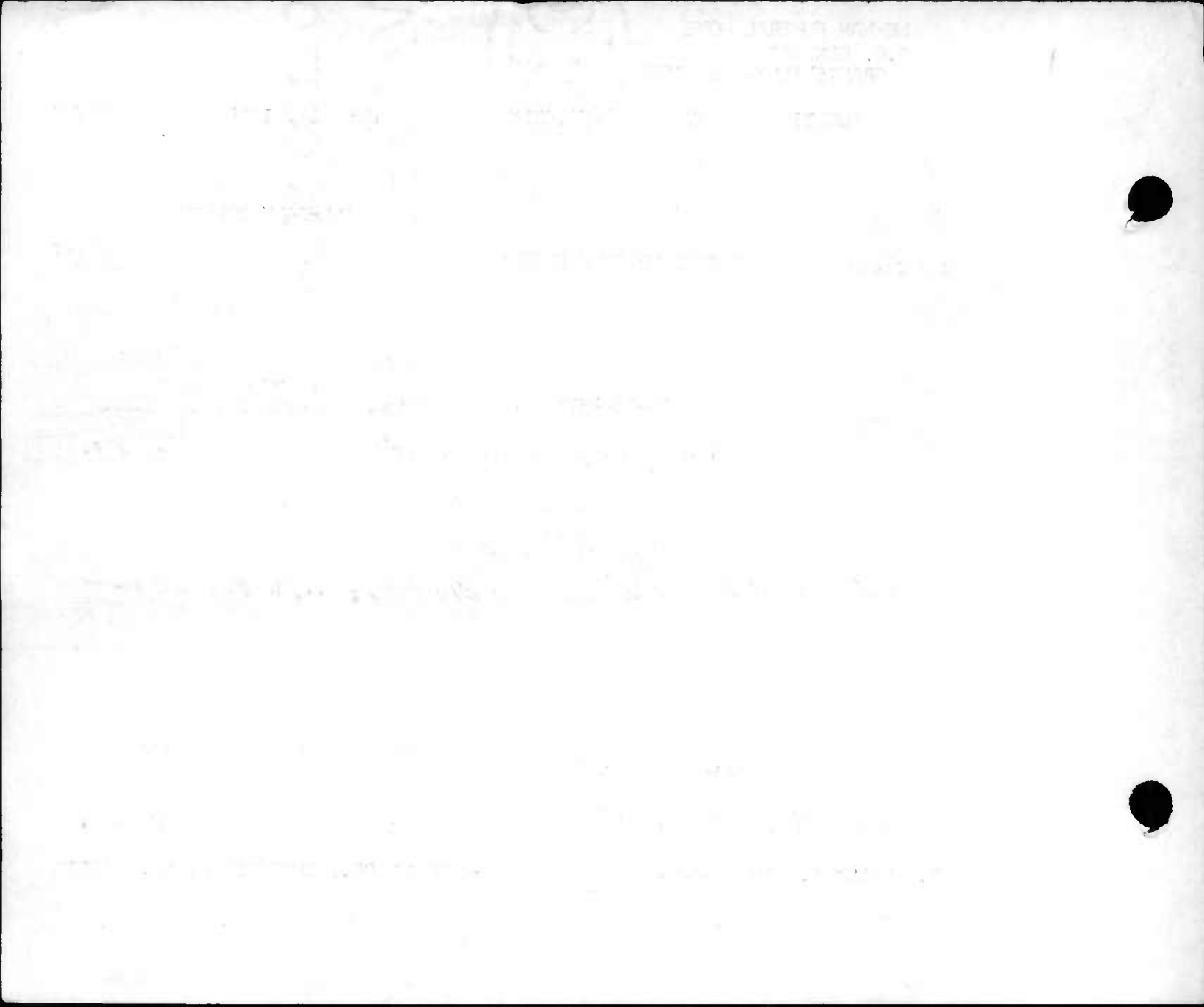
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8417754	
NEWMAN FUNERAL HOME P.O. BOX 267 GRANTSVILLE, MD 21536				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <div style="display: flex; justify-content: space-between;">QUENTINRAYFRICKEY</div>			2a. DATE OF DEATH MONTH DAY YEAR <div style="display: flex; justify-content: space-between;">JULY 14,1984</div>		2b. HOUR 3:50A _M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1923	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Frickey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corabelle Bittinger		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Setter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 215-16-4578		17. INFORMANT ADDRESS Star Route, Box 61 Carol Frickey, Grantsville, MD 21536	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus; chronic lung disease; periph. vas. disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23, 1984</u> , to <u>7/14, 1984</u> , that (I) (we) last saw the deceased alive on <u>7/14, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. Hijab, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/14/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WALLY S. HIJAB, M.D.		22e. ADDRESS 909-A SETON DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery	
24. FUNERAL DIRECTOR NAME <u>D. Newman</u> ADDRESS <u>Grantsville, MD</u>		23d. LOCATION CITY OR TOWN COUNTY STATE Bittinger, Garrett, Md.			
		25a. DATE REC'D. BY REGISTRAR <u>JUL 19 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William D. Frye			2a. DATE OF DEATH MONTH DAY YEAR 7/31/84		2b. HOUR M AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 2 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Celanease		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Beechwood St. 21539	
14. FATHER'S NAME FIRST MIDDLE LAST Eli Frye			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Percilla Knippenberg						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. (IF YES, GIVE WAR OR DATES) Korean		16c. SOCIAL SECURITY NO. 218-34-2533		17. INFORMANT ADDRESS Mr. William Frye Lonaconing, Md. 21539			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Moments 6 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/22 19 82 to 7/31/84 19 84 , that (I) (we) last saw the deceased alive on 11/8 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE M ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/7/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/3/84		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg Allegany Md.			
24. FUNERAL DIRECTOR NAME Boals Funeral Service Lonaconing, Md.				25a. DATE REC'D. BY REGISTRAR AUG 10 1984		25b. REGISTRAR'S SIGNATURE [Signature]			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLEONA GERMAINE						2a. DATE KNOWN OF DEATH MONTH DAY YEAR June 30 84		2b. HOUR 1000			
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10 1908		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 76		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR June 30 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Westernport		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Marsh Apts				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Marsh Apts 21562			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Nagel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Finkbiner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 379-24-2434		17. INFORMANT ADDRESS Marsden Germaine Westernport Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Sub-endocardial myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery heart disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 6 months years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Paul Snow</i>				TITLE (SPECIFY) M.D. Ast. Dpty				DATE SIGNED 6-30-84			
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.				ADDRESS Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial				23b. DATE 7/5/84		23c. NAME OF CEMETERY OR CREMATORY Hickory Corner Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hickory Corner Mich.			
24. FUNERAL DIRECTOR NAME Boal Funeral Service				ADDRESS Westernport Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

4

STATE OF NEW YORK
IN SENATE
January 10, 1907.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1906.
ALBANY:
J. B. LEECH, STATE PRINTER.
1907.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

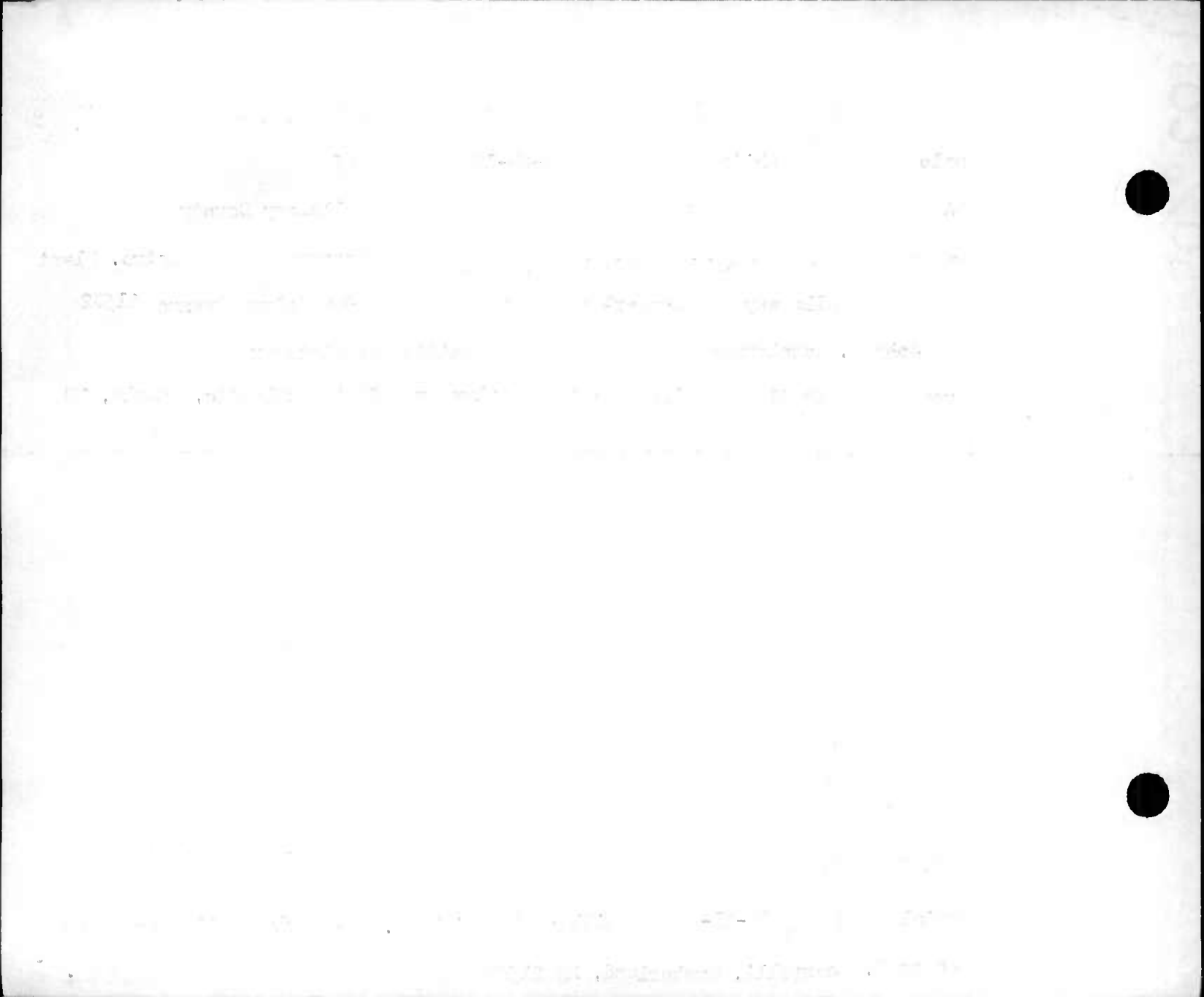
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD CHARLES HARCLERODE			2a. DATE OF DEATH MONTH DAY YEAR JULY 19, 1984			2b. HOUR 7:30 M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02-24-19		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Petro. Plant	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 900 Weires Avenue 21502	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Harclerode				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Mae Fletcher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II		17. INFORMANT ADDRESS Marlyn Frankfort Harclerode, LaVale, MD					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adverse drug reaction DUE TO, OR AS A CONSEQUENCE OF (b) Streptococcal pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 7/18/84 to 7/19/84 , and that (I) (my) opinion death occurred on the date and hour and from the cause stated.									
22b. SIGNATURE W. Guy Fiscus						DEGREE MD		22c. DATE SIGNED 7/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. W. GUY FISCUS						22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07-21-84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JUL 23 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

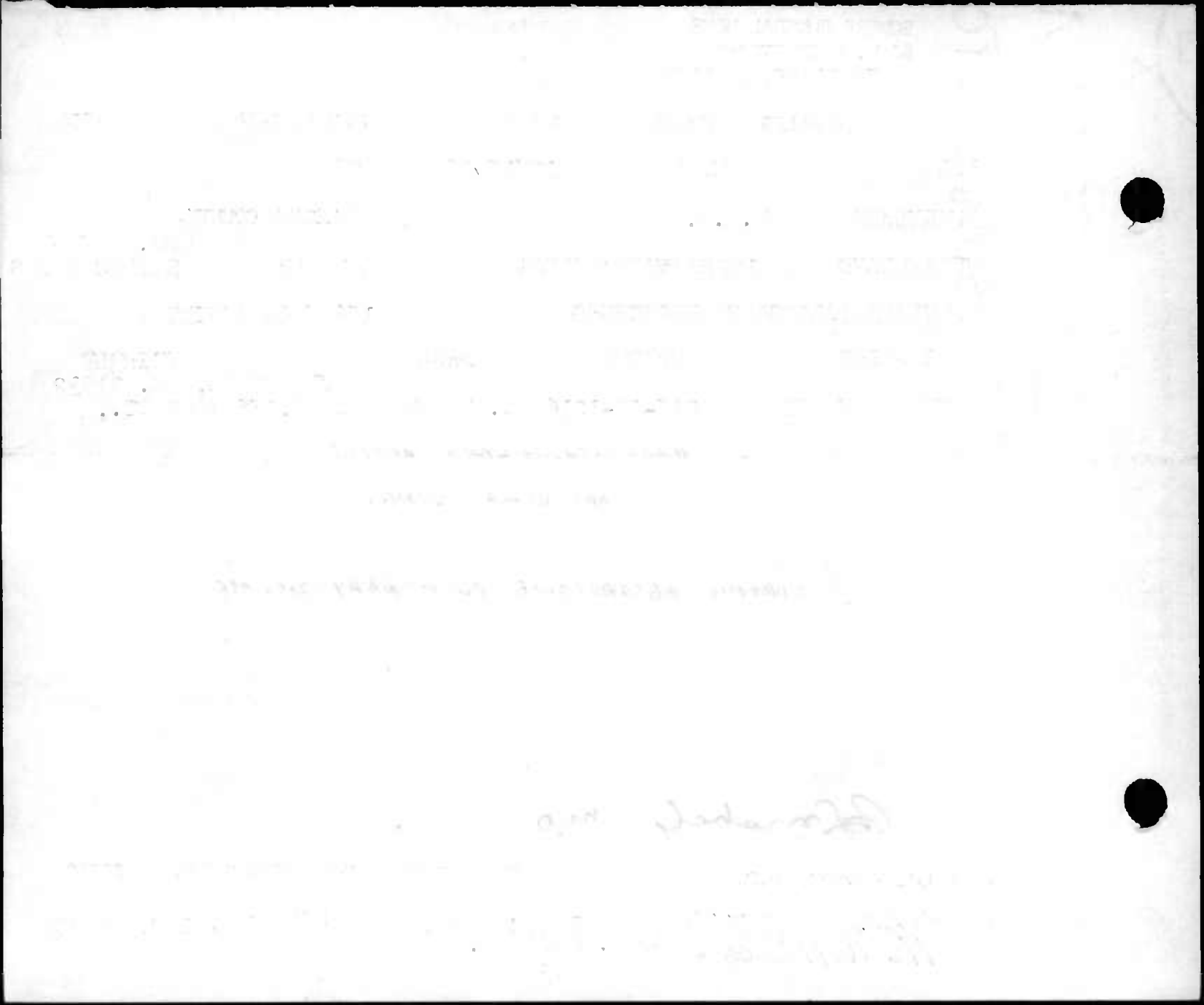
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SOWERS FUNERAL HOME				STATE OF MARYLAND			
1- FOR STATE REGISTRAR 60 W. MAIN STREET FROSTBURG, MD 21532				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
CHARLES EDWARD HARDEN				JULY 3, 1984			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))	
MALE		WHITE		MONTH DAY YEAR 12/15/06		78 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				ALLEGANY COUNTY, MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		LABORER		SAVAGE REFRACTORIES	
13a STATE				13b COUNTY			
MARYLAND				ALLEGANY			
13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
FROSTBURG				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
CHARLES EDWARD HARDEN				MABLE TRIMBLE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b SOCIAL SECURITY NO.			
YES WW II				215-10-1216			
17 INFORMANT				17 ADDRESS			
FROSTBURG, MD. 21532				156 WOOD STREET			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>CARDIOMEGALY LUNG.</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>B. Mahal</u> DEGREE <u>M.D.</u>						22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS	
BALJEET MAHAL, M.D.						909-B SETON DRIVE, CUMBERLAND, MD 21502	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		7/5/84		PORTER CEMETERY		ECKHART ALLEGANY MD	
24 FUNERAL DIRECTOR NAME <u>Barlow N. Sowers</u> ADDRESS <u>60 W. MAIN ST. FROSTBURG</u>				25 DATE REC'D BY REGISTRAR <u>JUL 10 1984</u> REGISTRAR'S SIGNATURE <u>John Davidson</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

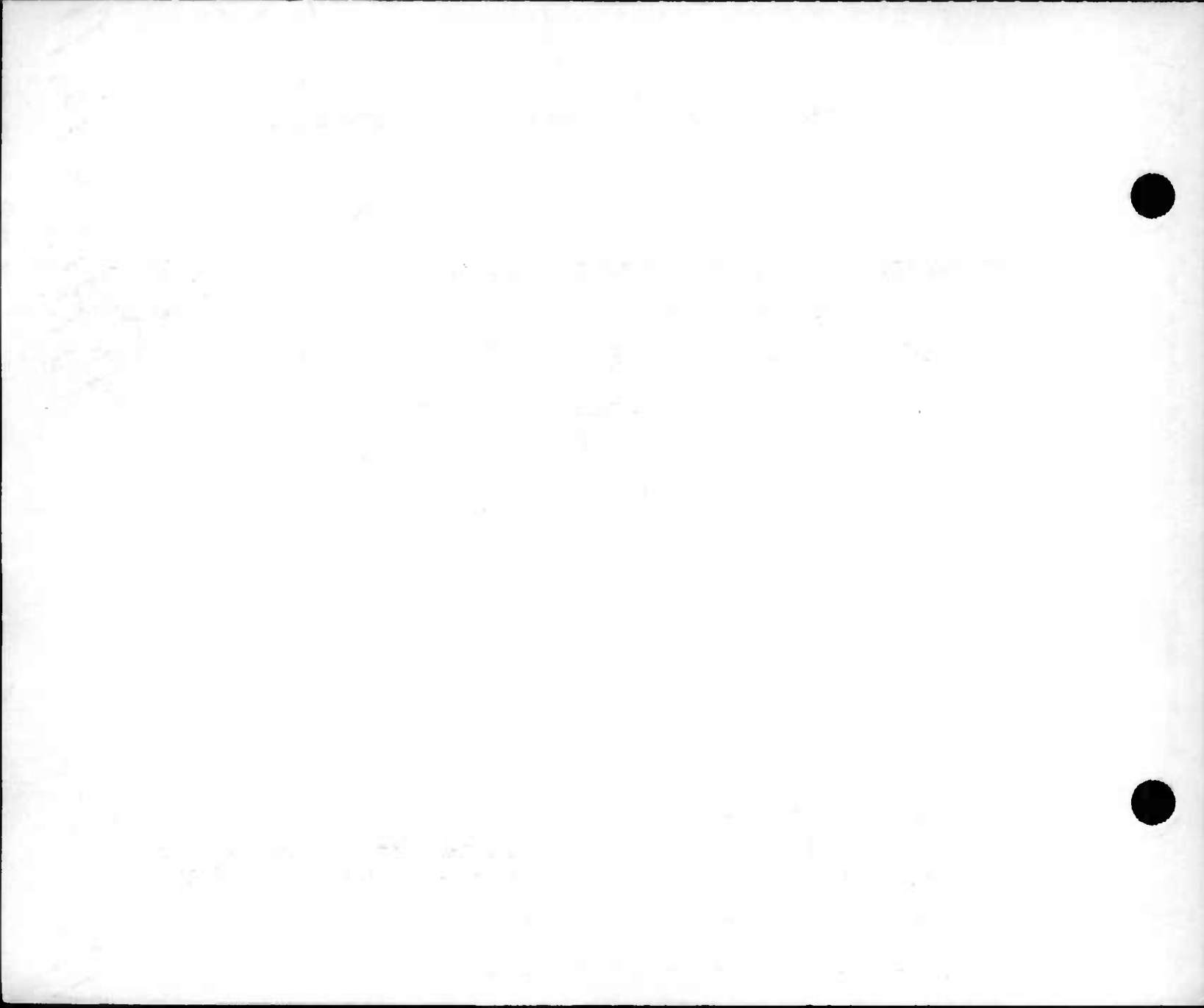
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7 4 1 7 7 5 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERLIN DAYTON HEDRICK				2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1984		2b. HOUR 7:50 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) worker		12b. KIND OF BUSINESS OR INDUSTRY Stroehmann Bread	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William S. Hedrick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Jane Nelson		13e. STREET ADDRESS / ZIP CODE Rt. 8 Box 170 Country Club Rd. 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-10-7819		17. INFORMANT Ruth Hedrick Rt. 8 Box 170 Country Club Rd.		ADDRESS Cumb., MD 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOCYTIC LYMPHOMA IV DUE TO, OR AS A CONSEQUENCE OF (b) ? LYMPHO SARCOMA CELL LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. QAMAR ZAMAN				22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/19/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant U. Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H. 404 Decatur St., Cumb., MD				25. DATE REC'D BY REGISTRAR JUL 20 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JAY HEFNER			2a. DATE OF DEATH MONTH DAY YEAR 07 10 84			2b. HOUR 3:45A M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 1 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAMES IN SUCH FACILITY - GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer, Dept.		12b. KIND OF BUSINESS OR INDUSTRY Amcelle Celanese Corp.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		
14. FATHER'S NAME FIRST MIDDLE LAST David -- Hefner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary V. Heavner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-1883		17. INFORMANT ADDRESS Rudolph Hefner - Reading, Pennsylvania		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain Syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 7-9 1984 to 7-9 1984 that (I) (we) lost saw the deceased alive on 7-9 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robustiano J. Barreca, Jr. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-10-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBUSTIANO J. BARRECA, JR.				22e. ADDRESS -Memorial Hosp. MEd. Bldg-Cumberland MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/84		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502				25a. DATE REC'D. BY REGISTRAR JUL 30 1984			
				25b. REGISTRAR'S SIGNATURE Lelia Davidson-Rondello			

BP

07 10 1964

WILLIAM JAY

WHITE

MALE

ALLEGANY COUNTY

RECORDS SECTION

CLERK AND

ALLIED CARLINS ROAD

ALLEGANY TOWNSHIP

WYOMING



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner was not found alive.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 1 6 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leah Virginia Hendrickson			2a. DATE OF DEATH MONTH DAY YEAR 7/23/84			2b. HOUR 9⁴⁵ AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15 1903		6. AGE (IN YEARS LAST BIRTHDAY) 31		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) textile worker		12b. KIND OF BUSINESS OR INDUSTRY Celenese		
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd #1 Flintstone, MD 21530	
14. FATHER'S NAME FIRST MIDDLE LAST Alvey Bender O'Neal			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Homans Ash							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-12-3805		17. INFORMANT ADDRESS Mrs. Norma Lapp Box 27C Gramlich Rd, LaVale, MD 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Parkinson's d DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 79 to 7/23 19 84 , that (I) (we) last saw the deceased alive on 7/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. HAZ MOS			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. HAZ MOS			22e. ADDRESS 302 Schley St. Cumberland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07/25/84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H.			ADDRESS 404 Decatur St., Cumb., MD 21502			25a. DATE REC'D. BY REGISTRAR JUL 31 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 / 6 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Thomas E. Higson		MONTH DAY YEAR 07 31 84	
3. SEX male		2b. HOUR 2:40PM	
4. RACE white		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		6. AGE (IN YEARS LAST BIRTHDAY) 65	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cumberland		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	
12b. KIND OF BUSINESS OR INDUSTRY dairy		13a. STREET ADDRESS 1512D Old Towne Manor	
13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1512D Old Towne Manor	
14. FATHER'S NAME FIRST MIDDLE LAST Harry H. Higson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude S. Duling	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-10-7882	
17. INFORMANT ADDRESS Ina Higson, Cumberland, MD - wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 19 84, to 7/31, 19 84, that (I) (we) last saw the deceased alive on 7/10, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE P. HALMOS	
22c. DATE SIGNED 8/3/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. HALMOS	
22e. ADDRESS 302 Schley St. Cumberland			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 08-03-84	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR AUG 9 1984	
25b. REGISTRAR'S SIGNATURE Jana Burdson-Randall			

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

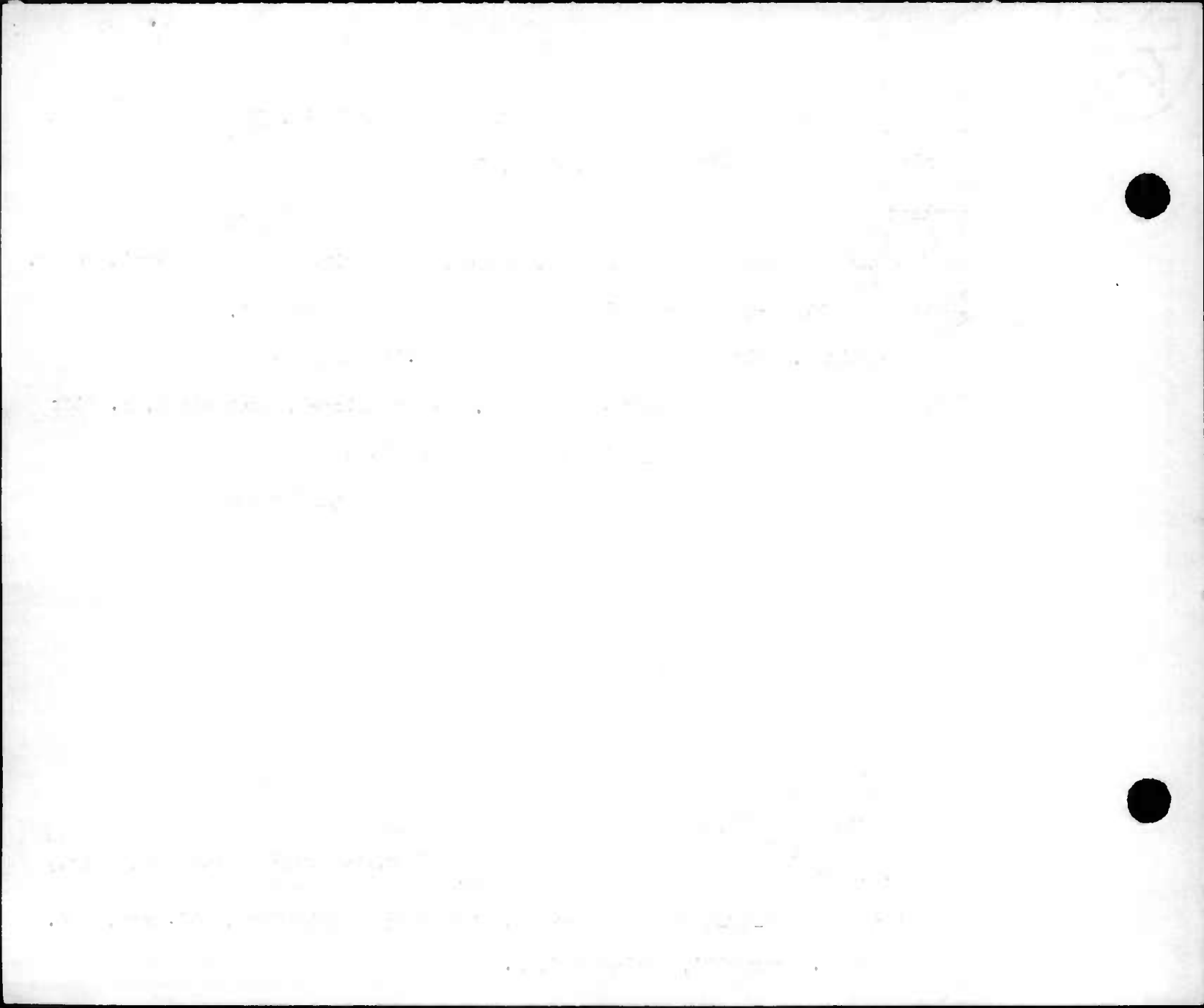
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8417163

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BOYD N HOLCOMB			2a. DATE OF DEATH MONTH DAY YEAR July 12, 1984		2b. HOUR 11:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1918		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver			12b. KIND OF BUSINESS OR INDUSTRY Furniture Co.			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 28 Boone St. 21502				
14. FATHER'S NAME FIRST MIDDLE LAST Martin L. Holcomb			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Ellen Jordan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-6363		17. INFORMANT Mrs. Evelyn Holcomb, Cumberland, Md. Wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED CA. OF ESOPHAGUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and I am the cause stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED 7/14/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Q. Zaman				22e. ADDRESS Medical Bldg., Memorial Hosp. & Med. Cntr., Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-15-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		23e. DATE REC'D. BY REGISTRAR JUL 17 1984				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17764

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM BURREL HUFFMAN			2r. DATE OF DEATH MONTH DAY YEAR July 2, 1984			2b. HOUR 4:11 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 04 19 16		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
						12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13r. STREET ADDRESS 719 N. Mechanic St./21502	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			
14. FATHER'S NAME FIRST MIDDLE LAST Calvin J. Huffman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chlorie M. Jordan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-03-7440		17 INFORMANT ADDRESS Georgia Huffman - same as above			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

48 hrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetic melitus

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/6/82 19 84 to 7/2 19 84 , that (I) (we) last saw the deceased alive on 7/1 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							

27a. SIGNATURE <i>Richard Snider</i>		DEGREE		27c. DATE SIGNED 7/3/84	
27b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Snider		27r. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/5/84		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Alleg., MD	
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24 FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD		25. DATE REC'D. BY REGISTRAR JUL 5 1984		26. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
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BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8

Male
Date
19 10 66
USA
X

19 10 66
USA
X
Jordan

19 10 66
USA
X
Jordan

19 10 66
USA
X
Jordan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

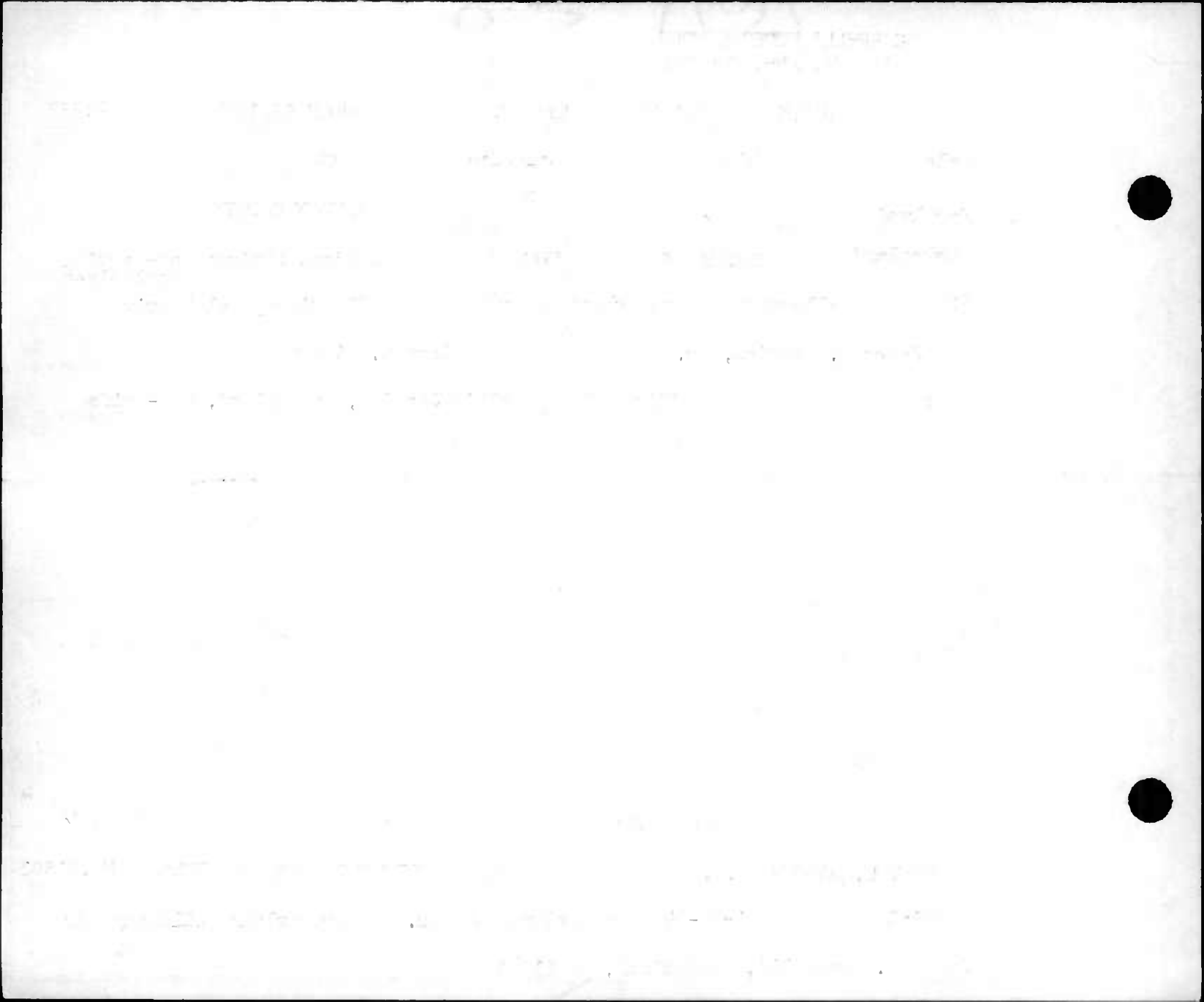
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 1 7 7 6 5	
1- SCARPELLI FUNERAL HOME STATE REGISTRAR 108 VA. AVE. CUMBERLAND, MARYLAND, CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR
JAMES HARRY JENKINS			JULY 05, 1984		4:55P _M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	MONTH DAY YEAR 01-19-10		74	YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland		SACRED HEART HOSPITAL		Retired Businessman-Banking	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		Allegany	Cumberland	13e. STREET ADDRESS / ZIP CODE 900 Bishop Walsh Drive 21502	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
James H. Jenkins, Sr.			Flora M. Simmonds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213104990		Nellie Jenkins, Cumberland, MD - wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CA Biliary Tree</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gary L. Wagoner</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-5-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY L. WAGONER M.D.			22e. ADDRESS 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07-07-84	23c. NAME OF CEMETERY OR CREMATORY SS Peter Paul Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 10 1984 <u>Lelia Davidson-Rendell</u>		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the medical examination must be notified or the medical examination must be notified.

MEDICAL CERTIFICATION

FOR BOALS FUNERAL HOME 1. STATE REGISTRAR LONA CONING, MD.				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 7 7 6 6					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
FIRST MIDDLE LAST				MONTH DAY YEAR				HOUR MIN.					
JACKIE LEE JUNKINS				JULY 29, 1984				7:00 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		MONTH DAY YEAR		51 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				ALLEGANY COUNTY MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				SACRED HEART HOSPITAL				Supervisor				Westvaco	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland				Allegany		Lonaconing		YES <input type="checkbox"/> NO <input type="checkbox"/>		9 Watercliff St. 21539			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS					
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Sheridan Junkins				Alma Hinebaugh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT							
(IF YES, GIVE WAR OR DATES)				212241036		Mrs. Eunice Junkins Lonaconing, Md.							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Cancer of Esophagus</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 min</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE					
								7/29/84 7/29/84					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29/84</u> to <u>7/29/84</u> , that (I) (we) lost													
saw the deceased alive on <u>7/29/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE <u>Renato Espina, M.D.</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22c. DATE SIGNED <u>7/30/84</u>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)													
RENATO ESPINA, M.D.													
22e. ADDRESS													
907 SETON DRIVE CUMBERLAND, MD. 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				8/1/84		Frostburg Mem. Park				Frostburg Allegany Maryland			
24. FUNERAL DIRECTOR													
Boals Funeral Service Lonaconing Md. 21539													
25a. DATE REC'D. BY REGISTRAR													
25b. REGISTRAR'S SIGNATURE													
AUG 3 1984													

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17757

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LaVerne NMI Kasecamp			2a. DATE OF DEATH MONTH DAY YEAR 7 28 84		2b. HOUR 6:00pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 21 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Frostburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt 3 Box 313 Frostburg 21532
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ANDERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLA MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 09 8926		17. INFORMANT ADDRESS MRS. LOIS GILLEN, RT. 3, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CARCINOMA OF THE BREAST WITH BONE AND BRAIN METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 26 19 84 to July 28 19 84 , that (I) (we) last saw the deceased alive on July 28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Chang		DEGREE M.D.		22c. DATE SIGNED 7/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang		22e. ADDRESS Frostburg Community Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-31-84	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ECKHART, MD.	
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.					

85
51
35
10

MEDICAL CERTIFICATION

9
9

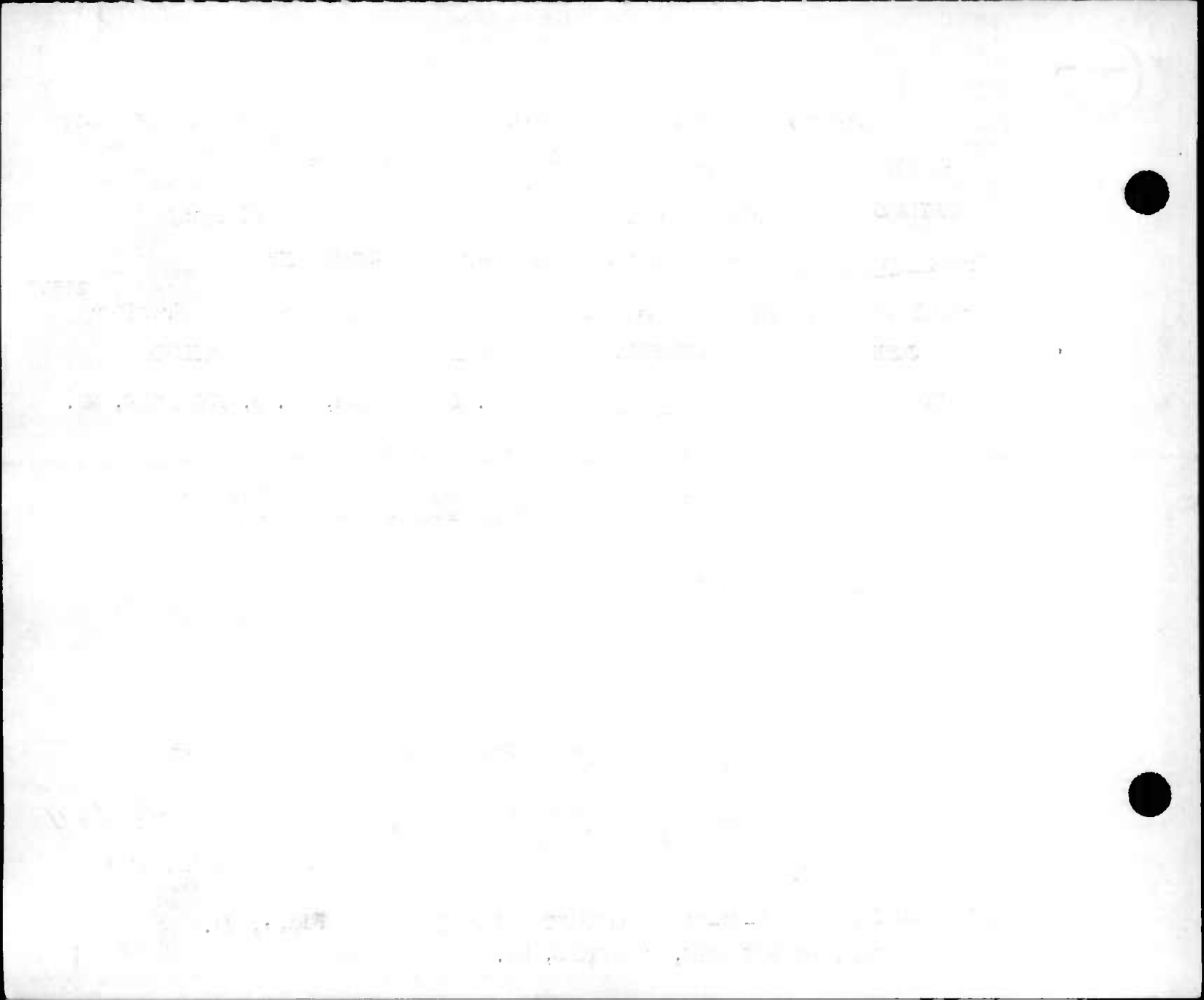
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTE: REGISTRAR'S SIGNATURE
AUG 7 1984
John Davidson-Randall

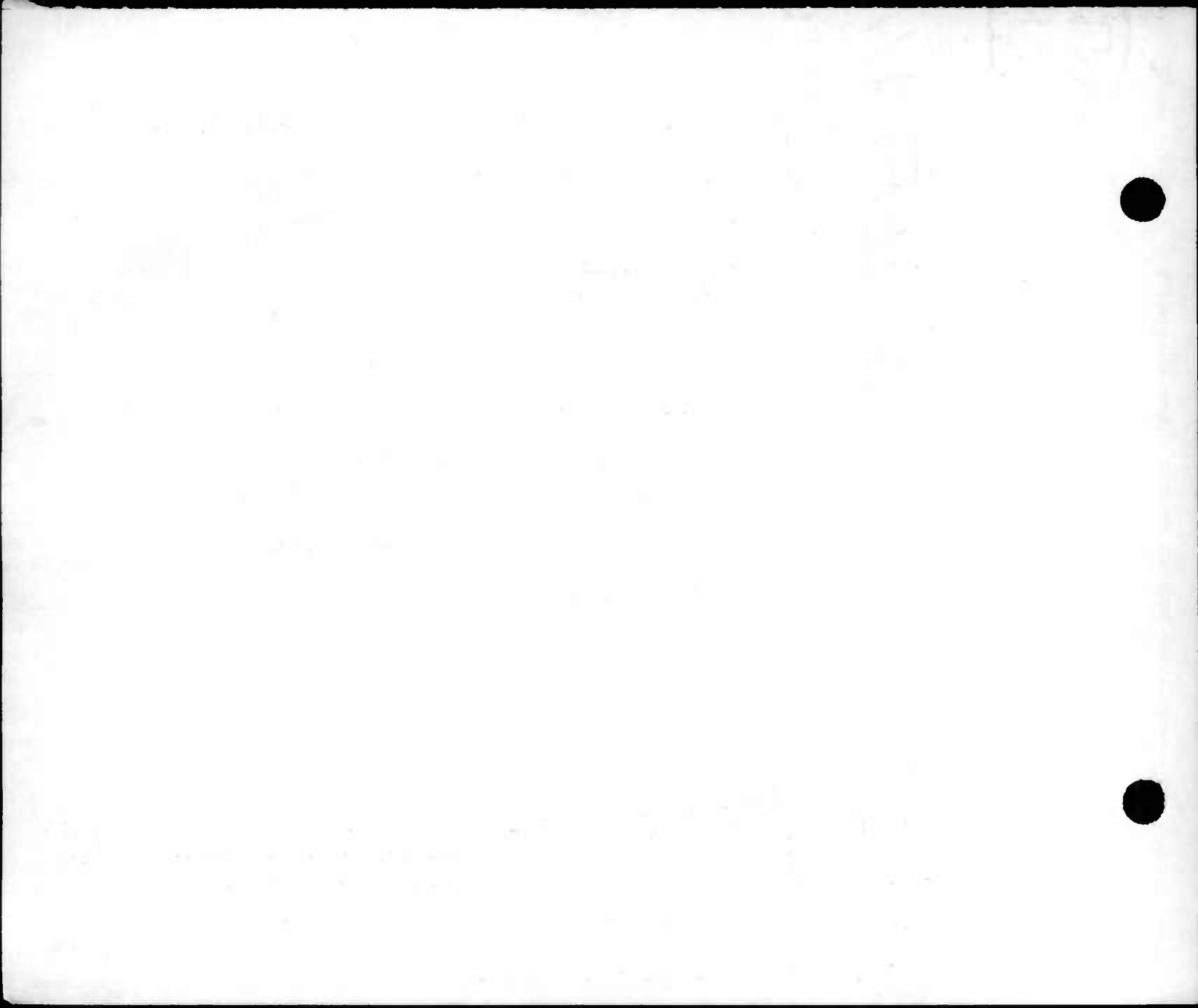


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ESTHER KAY KELLY					July 31, 1984						1:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	white	01-28-97			87 YRS			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
MD	USA				Allegany MD							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland	Memorial Hospital			housewife			home					
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				
MD				Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE						
John Knight				Mary (nmn)		405 Race Street 21532						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no				220-07-6206		William J. Kelly, LaVale, MD - son						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTEROSCLEROTIC HEART DISEASE</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>THORACIC AORTIC ANEURYSM.</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that on (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Dr. Amado Torres										7/31/84		
23a. PHYSICIAN'S NAME (TYPE OR PRINT)						23b. ADDRESS						
Dr. Amado Torres						Memorial Hospital Medical Building Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			08-03-84		Sunset Memorial Park			Cumberland Allegany MD				
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR				
James F. Scarpelli, Cumberland, MD 21502								AUG 3 1984				



FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

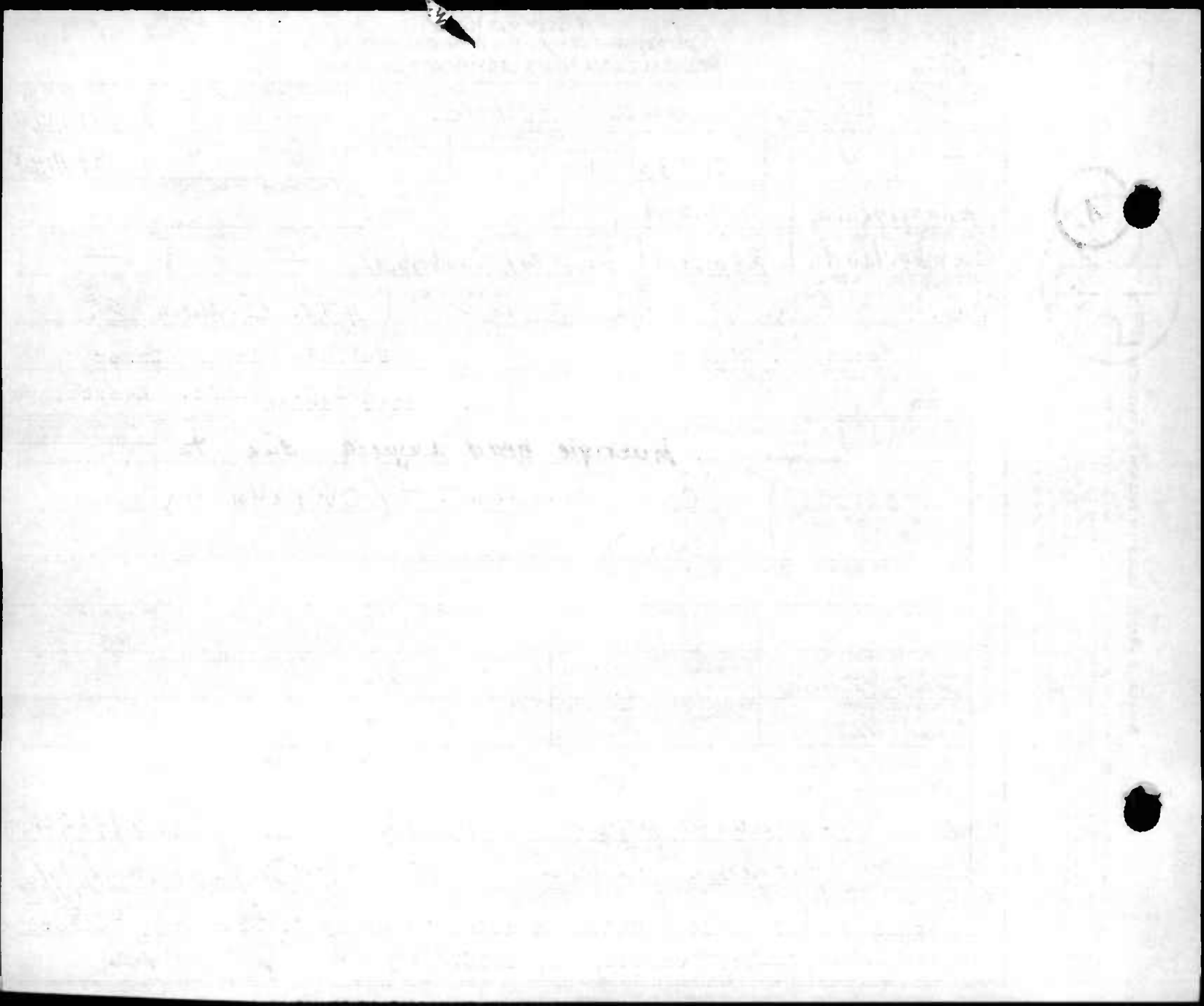
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR	
Heather Diana Kinser								7		9		19		84		11:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	W	1 21 83		1 YRS.						7		9		19		84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.		WIDOWED		DIVORCED		4112992X									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Memorial Hospital (Cumberland)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Pa.		Bedford		Everett		YES		432 E. Main St.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Kenney R. Kinser		Belinda Dicken Kinser															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no				Mr. Victor Dicken		432 E. Main St., Everett, Pa.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
8147 IMMEDIATE CAUSE (a) Multiple head injuries due to																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) Car accident - (over 84 by																	
(c) Car																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held in		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Francisco Reyes		Deputy		7/9/84													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Francisco Reyes		900 Seton Dr. Cumberland, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY											
burial		7-12-84		Union Memorial Cemetery E. Prov Twp, Bedford		Penn											
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
August Dalla Valle, Everett, Pa, 1553		JUL 16 1984		Julia Davidson-Randall													

BP

DHMH 17
(VR A15 ME (5))
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT - PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17770

1. FOR
STATE
REGISTRAR

REG. NO.

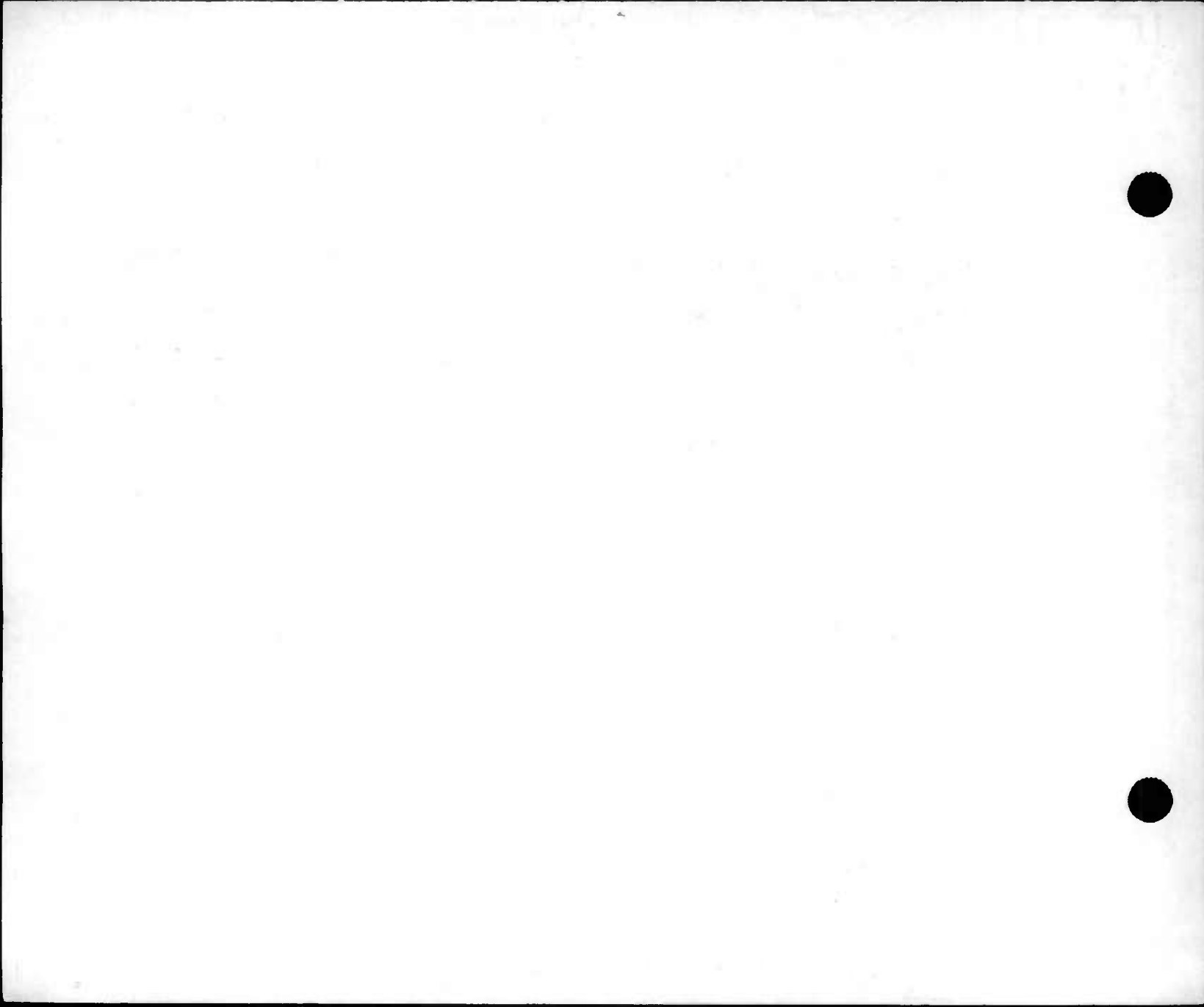
1. DECEASED NAME (TYPE OR PRINT) WILLIAM HENRY KISNER			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1984		2b. HOUR 10:45 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr 8 1937		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal	
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Kisner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Lowermilk		13e. STREET ADDRESS / ZIP CODE Church St. 21550			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 215 34 4490		17. INFORMANT Elizabeth Kisner Deer Park, Md		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage Massive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive intracranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION 7/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral hematoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Ashker, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Khedar Ashker				22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-84		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Deer Park Garrett Md.	
24. FUNERAL DIRECTOR NAME ADDRESS David A. Burdock Kitzmiller, Md. 21538				25a. DATE REC'D. BY REGISTRAR JUL 30 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 7 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna C. Lancaster			2a. DATE OF DEATH MONTH DAY YEAR 7 9 84			2b. HOUR 11:30P ^{AM}		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN ECKHART		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY STEELE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY MUSSETTER		13e. STREET ADDRESS / ZIP CODE ECKHART MINES 21528				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N.A. 216-46-5873		17. INFORMANT FROSTBURG, MD. 21532 MRS. CAROL McDONALD, 109 WRIGHT ST.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Left Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Failure, Pleural effusion, Diabetes, Asthma								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/9/84 to 7/9/84, that (I) (we) last saw the deceased alive on 7/9/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE S. Lal Sandhir, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/10/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Lal Sandhir, M.D.		22e. ADDRESS 48 Tarn Terrace Frostburg, MD 21532						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/12/84		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD		
24. FUNERAL DIRECTOR M. Sowers		60 W. MAIN ST. ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Ross		
SOWERS FUNERAL HOME FROSTBURG								

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/82
10/10/82
10/10/82

2 days
left 10 days before
Christmas 1982
Christmas 1982
Christmas 1982

10/10/82
10/10/82
10/10/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17772

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Byrle A Lease			2a. DATE OF DEATH MONTH DAY YEAR 7/16/84			2b. HOUR 12:00pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/3/97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United State		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleg. MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Alleg.		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Kaylor Circle / 21532	
14. FATHER'S NAME FIRST MIDDLE LAST Taylor --- McKenzie			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna --- Cecil						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 10 1641D		17. INFORMANT ADDRESS Darlene Lease-Box 5012-Cresaptown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 day									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertensive Cardiovascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> <u>84</u> <u>May</u> 19 <u>80</u> , to <u>7/16</u> <u>84</u> , that (I) (we) lost saw the deceased alive on <u>7/16</u> <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not view) the body after death.									
22b. SIGNATURE <u>S. L. Sandhir</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>7/16/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. L. Sandhir				22e. ADDRESS 48 Tarn Terrace, Frostburg MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/19/84		23c. NAME OF CEMETERY OR CREMATORY Lease Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cresaptown-Allegany Co., Md.			
24. FUNERAL DIRECTOR NAME George's Upchurch				ADDRESS Cumberland, MD		25a. DATE REC'D. BY REGISTRAR JUL 30 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

35
10

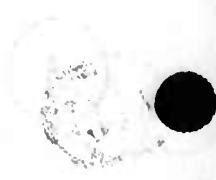
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

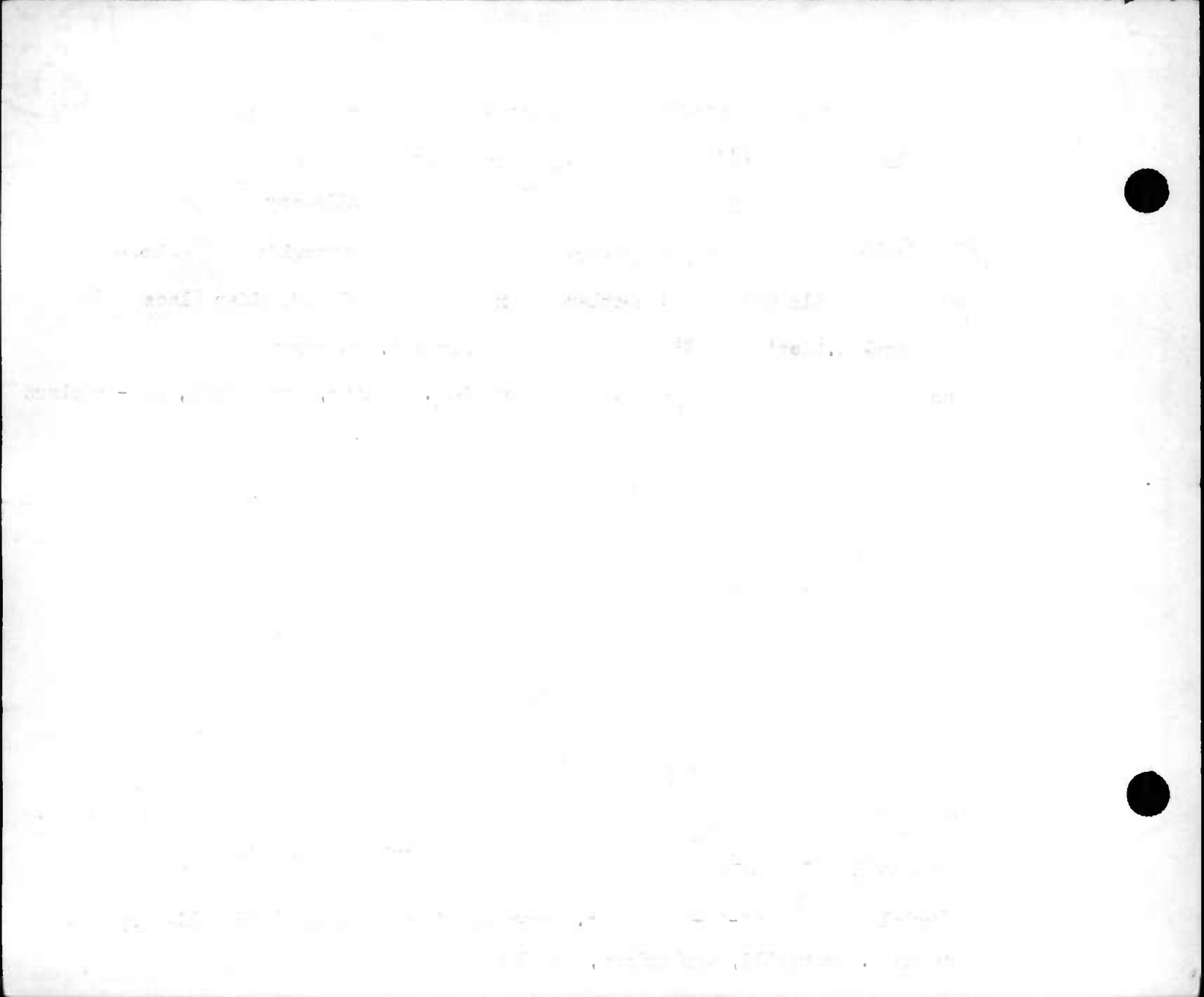
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANE CATHERINE LEASURE			2a. DATE OF DEATH MONTH DAY YEAR JULY 22, 1984		2b. HOUR 5:15 P.M.	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 18 07		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Frank C. (Matt) Matt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes V. Cosgrove			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-07-1117		17. INFORMANT ADDRESS Joseph W. Leasure, Cumberland, MD - husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE ANTERIOR MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERIOSCLEROSIS & INSUFF.</u> Approximate interval between onset and death: <u>3 HRS.</u> <u>4 HRS.</u> <u>OVER 2 YEARS</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSION - AORTIC SCLEROSIS - MITRAL INSUFFICIENCY</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 31</u> , 19 <u>50</u> to <u>JULY 22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>JULY 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Samuel Jacobson</i>				22c. DATE SIGNED 7-23-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SAMUEL JACOBSON				22e. ADDRESS 50 Pershing Street Cumberland, Maryland 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07-25-84		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		23e. DATE REC'D. BY REGISTRAR JUL 27 1984				
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						
25. REGISTRAR'S SIGNATURE <i>Davidson</i>						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 7 4

1. FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM HOMER LOHR			2a. DATE OF DEATH MONTH DAY YEAR JULY 6, 1984		2b. HOUR 2:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 28 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Garrett	7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegheny Co. MD.
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant	12b. KIND OF BUSINESS OR INDUSTRY Food
13a. STATE Pa.	13b. COUNTY Somerset	13c. CITY OR TOWN Addison	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Main 99999	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Lohr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Virginia Lee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 181-18-5952		17. INFORMANT ADDRESS Oma Lohr R. D. 1 Box 200A Addison, Pa. 15424	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESP ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) PNEUMONIA + RESP FAILURE - 1 MO DUE TO, OR AS A CONSEQUENCE OF: (c) FIBROSING ALVEOLITIS - 1 MO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION 6/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FIBROSING ALVEOLITIS OPEN LUNG BY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 6/21/84 to 7/6/84 that (I) (we) last saw the deceased alive on 6/21/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If I we) did not see the body after death.					
23a. SIGNATURE DR. NATHAN		DEGREE MD		23b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NATHAN		23d. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 9, 1984	23c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Addison Somerset Pa.	
24. FUNERAL DIRECTOR NAME Paul D. Dorman		ADDRESS Box 37 Confluence, Pa.		25. DATE REC'D. BY REGISTRAR JUL 12 1984	
				26. REGISTRAR'S SIGNATURE Julia Davidson	

MEDICAL CERTIFICATION

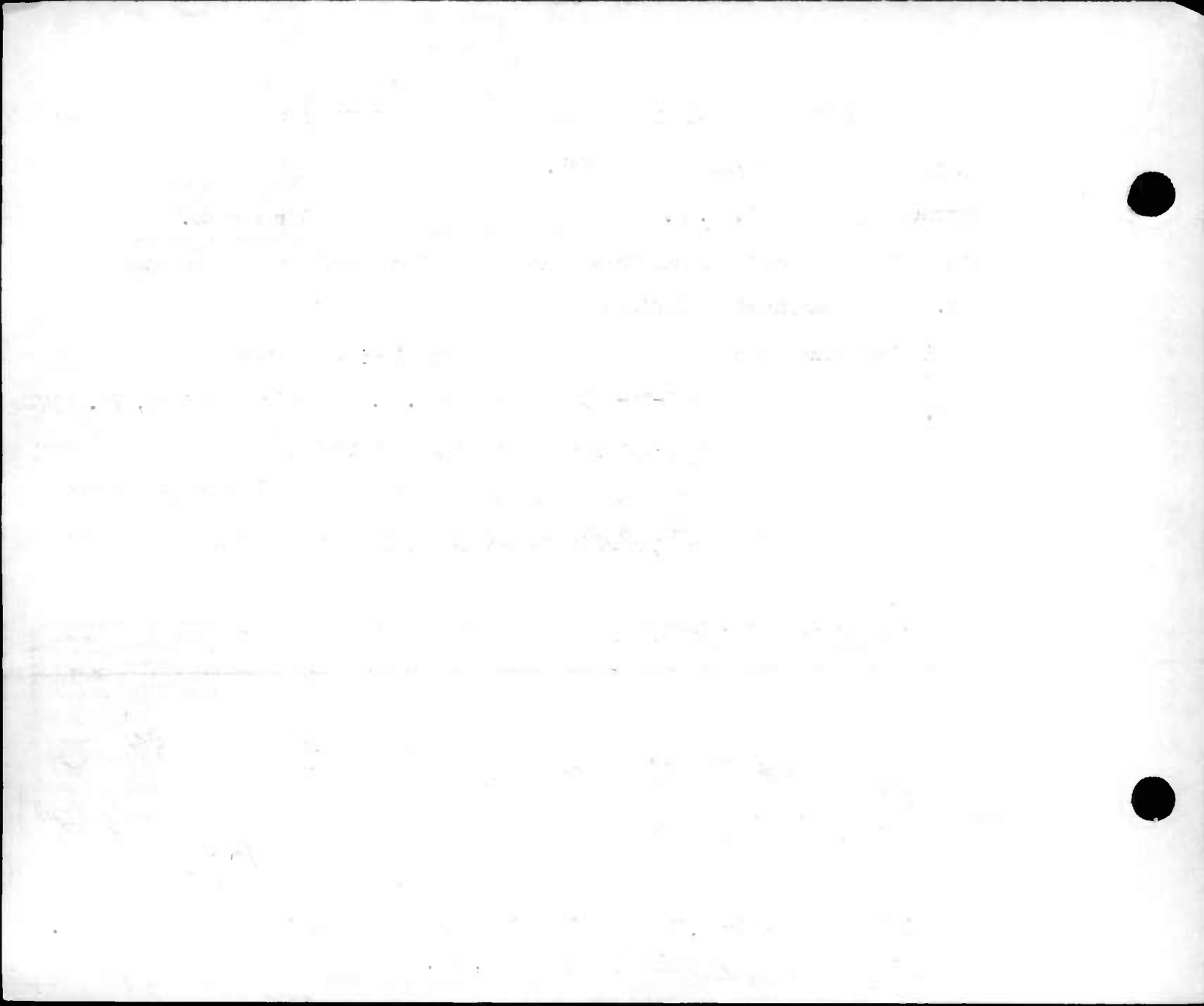
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or filled in, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

OHMH - 16 50M 4/83



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
ISM 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		6:00					
Mary		Lillian		Lynch				2c. DATE OF ESTI-MATED DEATH		Jul. 3, 19		84		a		M					
3. SEX	4. RACE	5. DATE OF BIRTH		YEAR		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		6:00	
Female	White	Jun. 13, 1904		80		YRS.		MONTHS		DAYS		HOURS		MIN.		Jul. 3, 19		84		a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH													
W.Va.		USA		WIDOWED		X		Allegany													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Cumberland		Memorial Hospital		Housewife		Own Home															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		Allegany		Cumberland		YES X NO		323 Davidson Street												21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Taylor		Collins		Fannie		Nichols															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No		214-07-2517		William A. Lynch		Cumberland, MD															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																Sudden					
IMMEDIATE CAUSE (a) Pulmonary Embolism																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) Phlebothrombosis																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) Hip Surgery Right Side																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
June 28, 1984				Right hip broken								YES NO X									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
X				2:00 P.M. Jun 28 84				Fell at home													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
				at home				323 Davidson St., Cumberland Allegny MD													
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes X Accident Suicide Homicide Undetermined manner																					
22b. I certify that I took charge of the remains described above, held on death resulted from Natural causes X Accident Suicide Homicide Undetermined manner																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED													
Francisco Reyes				Deputy				Jul. 13, 84													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Francisco Reyes, M. D.				Sacared Heart Hospital																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				Jul. 5, 1984				Zion Memorial Park				Cumberland Allegny MD									
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
William G. Kight				Jul 13 1984				Julia Davidson-Randall													

24. FUNERAL DIRECTOR

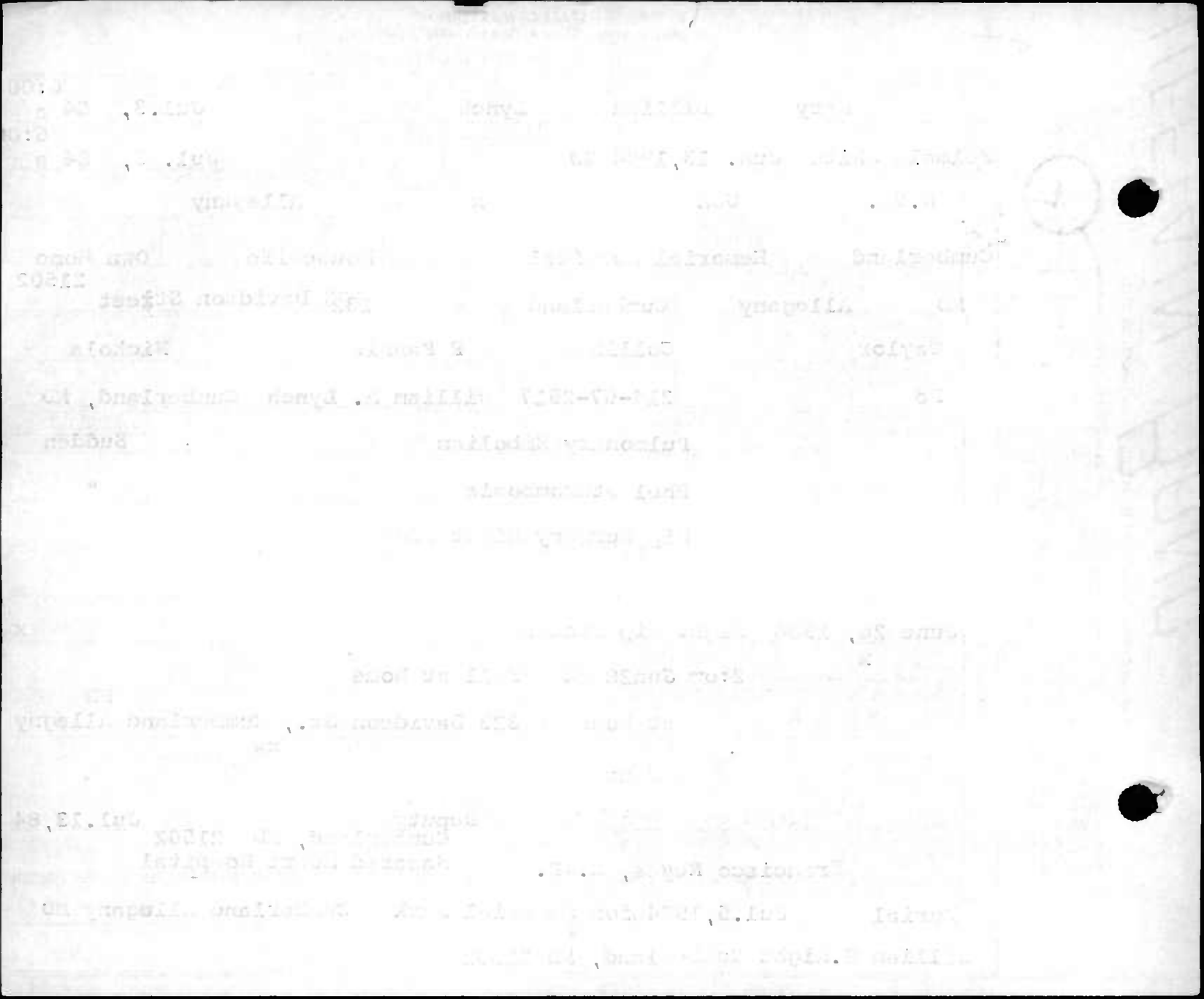
NAME ADDRESS William G. Kight Cumberland, MD 21502

25a. DATE REC'D. BY REGISTRAR

Jul 13 1984

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8417776

1- FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leafy Matthews			2a. DATE OF DEATH MONTH DAY YEAR 7 2 84		2b. HOUR 5:30p M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 12 93		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LAWSON MONTGOMERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISA MONTGOMERY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSP. RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of Liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 Severe Diabetes Mellitus					
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ✓		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ✓	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ✓		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ✓	
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 1980 , to 07-02 1984 , that (I) (we) last saw the deceased alive on 07-02 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Rothstein, M.D.				22c. DATE SIGNED 07/03/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Rothstein, M.D.				22e. ADDRESS Frostburg, MD 21532	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/6/84	23c. NAME OF CEMETERY OR CREMATORY PHILLOS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTERNPORT, ALLEGANY MD.
24. FUNERAL DIRECTOR RABSON'S SERVICE BOALS FUNERAL SERVICE WESTERNPORT				25a. DATE REC'D. BY REGISTRAR 10 1984	
				25b. REGISTRAR'S SIGNATURE Felix Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

Handwritten notes in the top left corner, including the word "Columbus" and other illegible text.

Handwritten text in the center of the page, possibly a title or a section header.

Handwritten text in the middle of the page, appearing to be a date or a specific reference.

Handwritten text in the bottom right area, possibly a signature or a concluding note.

Handwritten text at the very bottom of the page, likely a footer or a final remark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The I

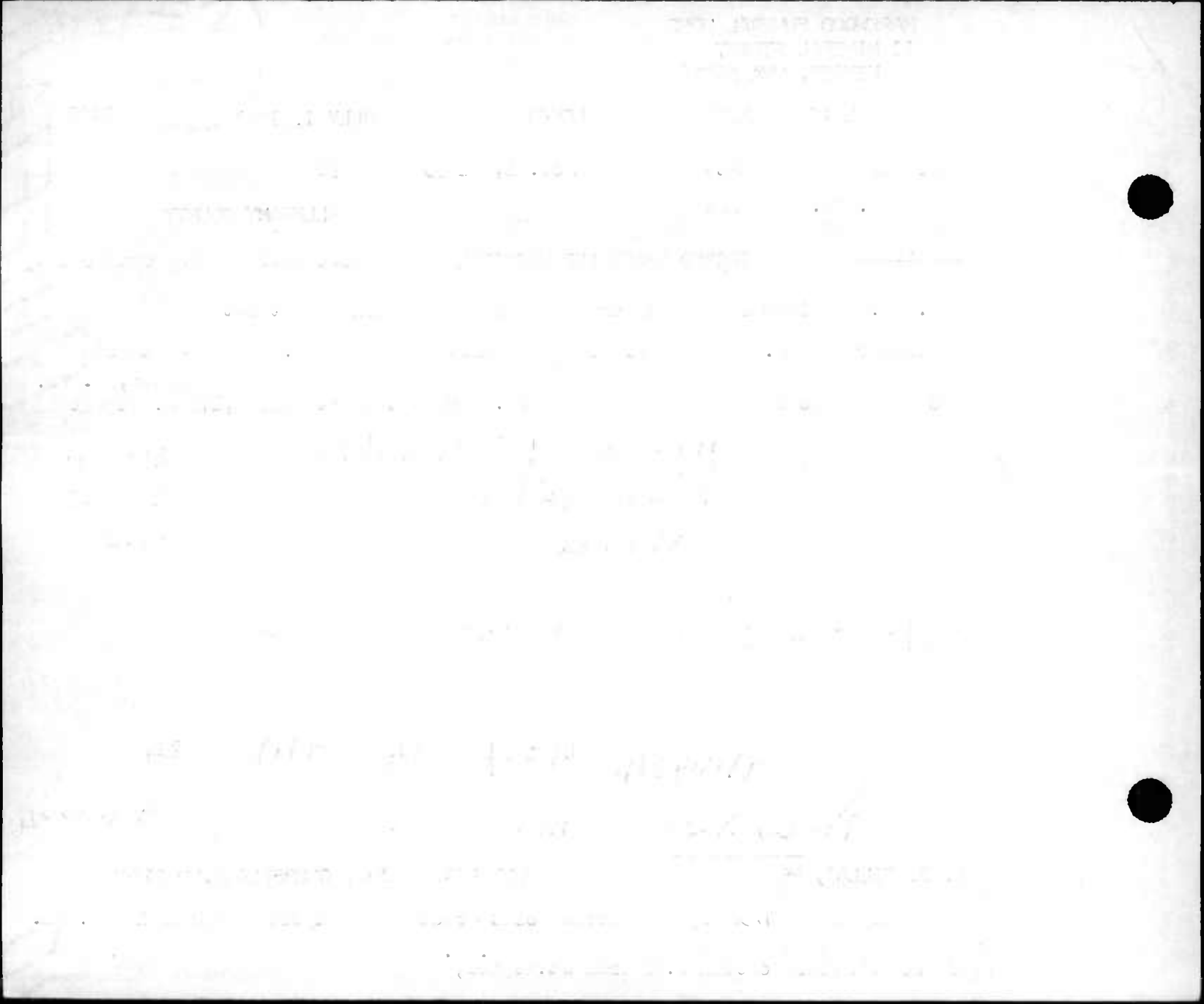
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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If H

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR 11 MINERAL STREET KEYSER, WVA 26726		MARKWOOD FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 4 1 7 7 7 7	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS MEDA MCKEE		2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1984		2b. HOUR 2:05 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 1, 1893	
6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		8. CITIZEN OF WHAT COUNTRY? USA	
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STATE W. Va.	
13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Richard D. Drake		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Penrod		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Catherine Murray		ADDRESS Keyser, W. Va. 171 D. Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Stroke		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 1 wk.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no	
19a. DATE OF OPERATION 6/25/1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of foot		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 6/25/1984		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 7/1/1984	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 711 1984		22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE A. S. Pillai, MD	
22c. DATE SIGNED 7/1/1984		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. S. PILLAI, MD		22e. ADDRESS 915 SETON DRIVE, CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/84		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.		24. FUNERAL DIRECTOR Markwood Funeral Home		25a. DATE REC'D. BY REGISTRAR 9 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. REGISTRAR'S NAME Julia Davidson-Randall		25d. REGISTRAR'S ADDRESS 11 S. Mineral St. Keyser, W. Va.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BOALS FUNERAL HOME 111 CHURCH STREET WESTERNPORT, MD. 21562				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 4 1 7 7 7 8	
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HOMER LEE MICHAEL				2a. DATE OF DEATH MONTH DAY YEAR JULY 20, 1984		2b. HOUR 4:05A _M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 1/30/07		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY ELECTRIC CO.	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J. ELLSWORTH MICHAEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA B. WARNICK		13e. STREET ADDRESS / ZIP CODE 229 WALNUT ST. 21562			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 2 232-01-1308		17. INFORMANT ADDRESS OKEY MICHAEL SPRUCE ST., WESTERNPORT, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, DUE TO, OR AS A CONSEQUENCE OF CIRCULATORY COLLAPSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>V.K. Suresh Rajan</i>				DEGREE M.D.		22c. DATE SIGNED 7/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. V.K. SURESH RAJAN, M.D.				22e. ADDRESS P.O. BOX 1722, CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 23, 1984		23c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTERNPORT ALLEGANY MD.	
24. FUNERAL HOME BOALS FUNERAL SERVICE WESTERNPORT, MD. 21562				25a. DATE REC'D BY REGISTRAR JUL 31 1984			
25b. REGISTRAR'S SIGNATURE <i>Julia Hudson-Randall</i>							

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

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UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C. 20315

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

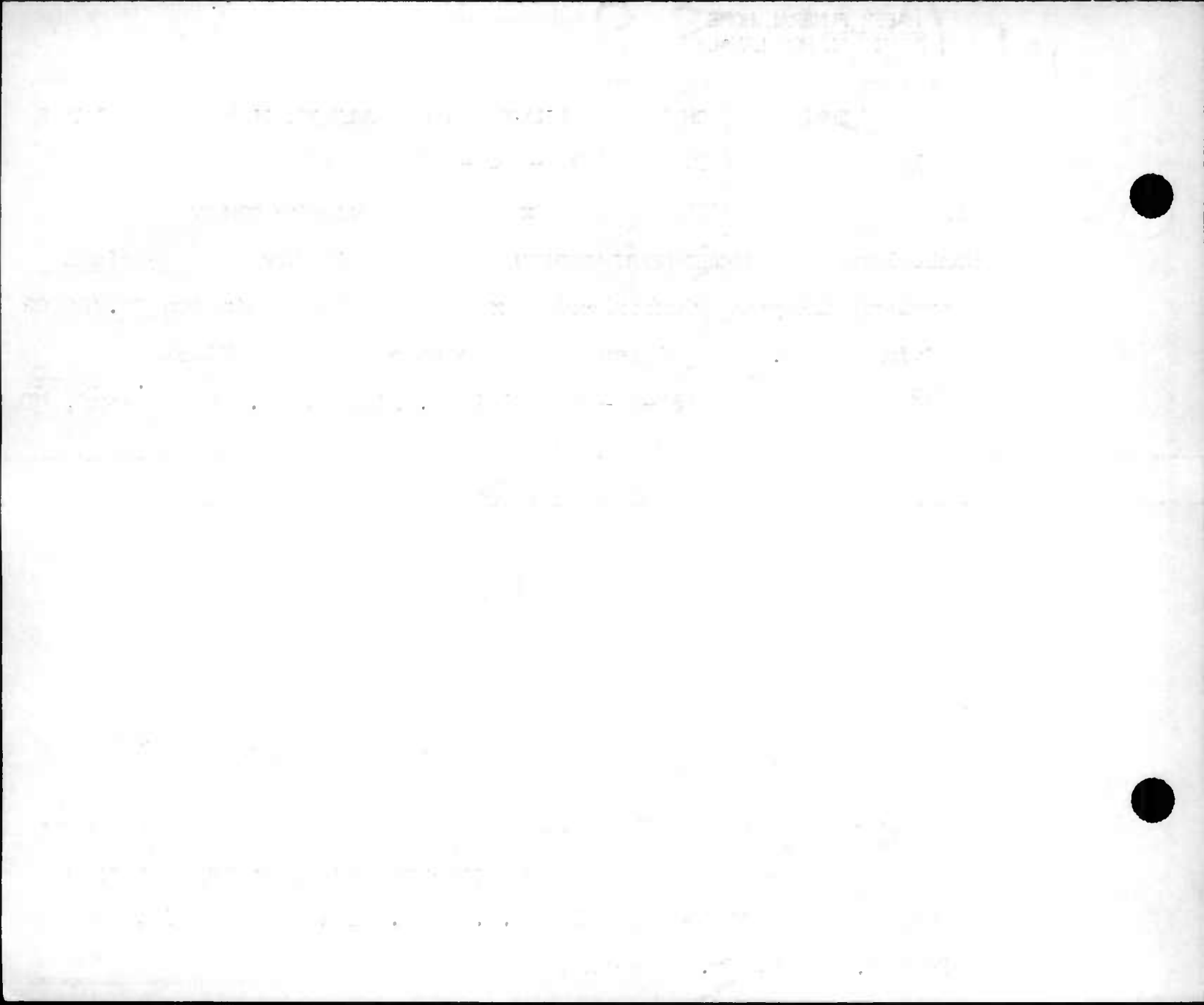
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IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

HAFER FUNERAL HOME 1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				84 17779 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWIN CHRIS MILLER MD				2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1984				2b. HOUR 1:30 P.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 - 10 - 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor		12b. KIND OF BUSINESS OR INDUSTRY Medical			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 635 Washington St./21502			
14. FATHER'S NAME FIRST MIDDLE LAST Edwin B. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Nicols							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 163-32-0156		17. INFORMANT ADDRESS Balto. Street Edwin C. Miller, Jr. Cumberland, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>June 1983</u> to <u>July 30, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>July 31, 84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/84		23c. NAME OF CEMETERY OR CREMATORY Trinity U.M. Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Portage Cambria, PA					
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.				ADDRESS LaVale, MD		25a. DATE REC'D. BY REGISTRAR AUG 1 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

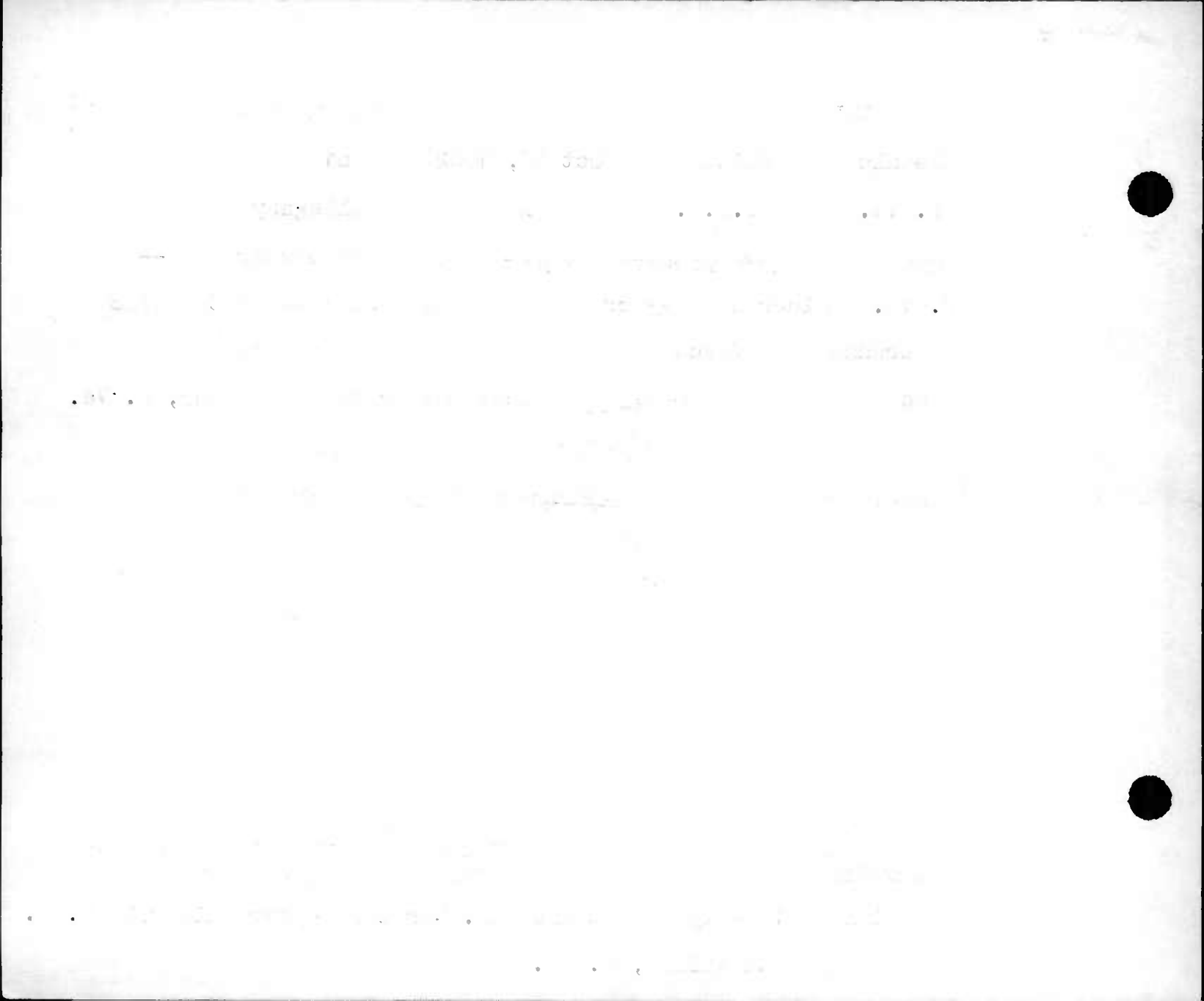
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 17780

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE SUSAN MILLER			2a. DATE OF DEATH MONTH DAY YEAR JULY 12, 1984			2b. HOUR 10:15 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 28, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE W. Va.	13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt 1 Box 58C 26726 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Veach			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 233-84-1269		17. INFORMANT ADDRESS Anna Lee Newman Keyser, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIC ENCEPHALOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAUSED BY CARDIO RESP. Arrest</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Chronic obstructive Pulm Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulm Disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive Cardiac Failure, Arterio Sclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D.		22c. DATE SIGNED 7/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 July 84		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens Keyser		23d. LOCATION CITY OR TOWN COUNTY STATE Mineral W. Va.	
24. FUNERAL DIRECTOR NAME ALLEN ROTRUCK KEYSER, W. VA.				25a. DATE REC'D. BY REGISTRAR JUL 20 1984			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
RAYMOND HENRY MOATS						7 29 19 84						0050 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			2b. HOUR			
Male	White	10 25 27	56 YRS.	MONTHS DAYS HOURS MIN				7/29/84 19			0050 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia		U.S.A.				Allegany MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital				Farmer				Gen. Farming				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
W.Va.		Pendleton		Moyers		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Moyers Road 99999						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
Berlin				Della Moats										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
Yes				Korea 51-53		John Andrew Moats, Franklin, W.Va.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound to the head.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 13 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
				Self inflicted	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Giovanni Mastrangelo</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Dr. Giovanni Mastrangelo		ADDRESS 900 Seton Dr.		Cumberland, Md. 21502	

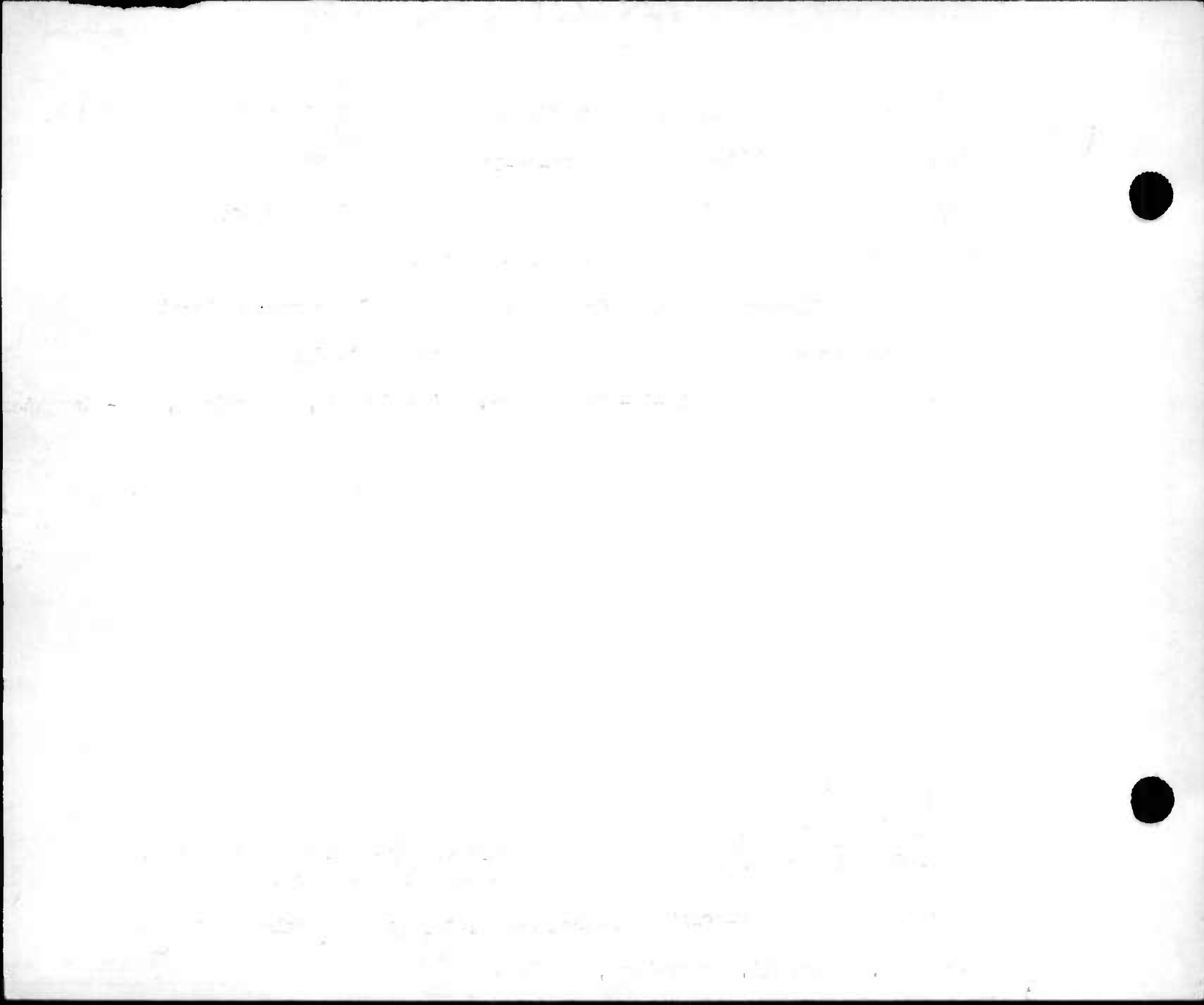
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	Aug. 1, 1984	Moats Cemetery	Moyers Pendleton W.Va.
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY	
NAME ADDRESS Basagic Funeral Home Franklin, W.Va.		AUG 15 1984	



W. H. Hall

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FRANK MORGAN			7-30 1984			1045A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	Cau	12/21/21	62 YRS.	MONTHS	DAYS	7-30 1984		1130A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		U.S.A.				Allegany MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Frostberg		43 Maple St. Frostberg Md				MAINTENANCE		COLLEGE
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE OR OF ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE MARYLAND 13b. COUNTY ALLEGANY 13c. CITY OR TOWN FROSTBURG				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		43 MAPLE STREET		21532
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
JAMES A. MORGAN, SR.			MARGARET LEWIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			N.A.		FROSTBURG, MD. 21532 MRS. FRANK MORGAN, 43 MAPLE ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac arrest								Sudden
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) Coronary artery heart disease								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
Post myocardial infarction and Cerebral vascular accident, two years								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
<i>Paul Snow</i>			M.D. Ast. Dpty MEDICAL EXAMINER				7-30-84	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Paul Snow, M.D.			Memorial Hospital, Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			8/2/84			FROSTBURG MEM. PARK FROSTBURG ALLEGANY MD.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
W. MAIN ST. FROSTBURG			AUG 3 1984			<i>Jana Davidson-Randall</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

SOWERS FUNERAL HOME

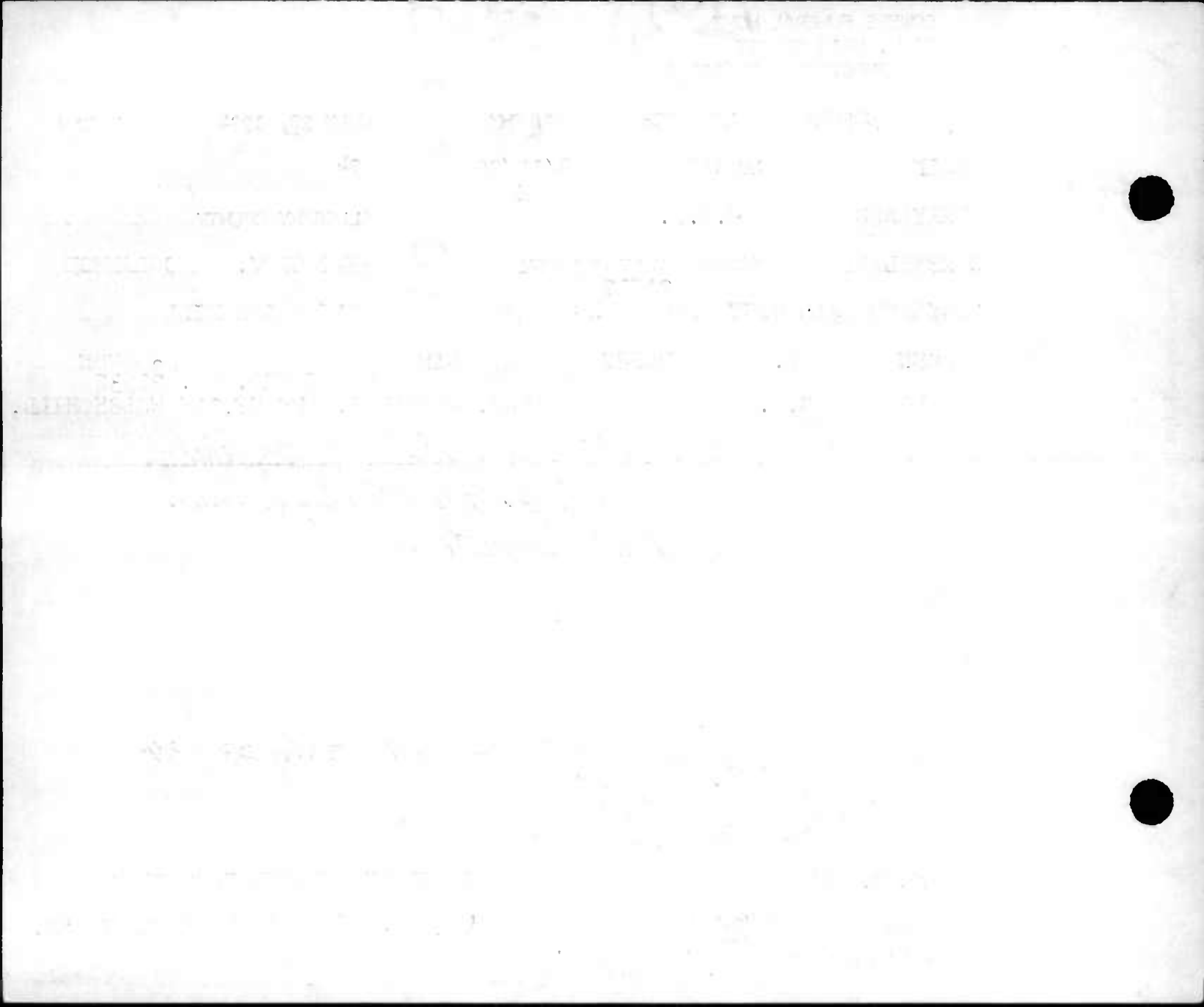
1. FOR STATE REGISTRAR
60 W. MAIN STREET
FROSTBURG, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH LAWRENCE MURPHY			2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1984			2b. HOUR 7:00 A.M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8/10/09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIFT SUPV.		12b. KIND OF BUSINESS OR INDUSTRY CELANESE		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN P. MURPHY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN McMAHON			13e. STREET ADDRESS / ZIP CODE 215 WELSH HILL 21532				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N.A.			16b. SOCIAL SECURITY NO.		17. INFORMANT FROSTBURG, MD. 21532 MRS. JOSEPH L. MURPHY, 215 WELSH HILL,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident - Rt. Hemiplegia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma lung, (t. carotid artery occlusion)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD, Emphysema</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from July 15, 19 84, to July 28, 19 84, that (I) (we) last saw the deceased alive on July 28, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
27b. SIGNATURE <i>Bliss E. Kim</i>			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27c. DATE SIGNED	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S. KIM			27e. ADDRESS 90 MAIN STREET, WESTERMPORT, MD 21562							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/30/84		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD.			
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME, 60 W. MAIN ST. FROSTBURG			25a. DATE REC'D. BY REGISTRAR AUG 3 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DURST FUNERAL HOME 57 FROST AVENUE FROSTBURG, MD. 21532				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 7 7 3 6			
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
ALICE AGNES MURRAY				JULY 10, 1984				2:35AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		FEB. 26, 1906		78		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL				HOMEMAKER		OWN HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		84 BROADWAY 21532			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
WILLIAM WINNER				EMMA HEMING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				705055210		JAMES M. MURRAY, SAME AS 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) C.V.A. - Probable Brain Tumor											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
① Dial. Mellitus ② Hx. of Recent M.I. ③ Hypertension											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
C. Vincent MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
DR. CLARENCE VINCENT, M.D.				909-B SETON DR., CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				JULY 12'84		ST. MICHAEL CEM.		FROSTBURG, ALLEGANY, MD.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS											
DURST FUNERAL HOME, FROSTBURG, MD.						JUL 17 1984					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 / 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

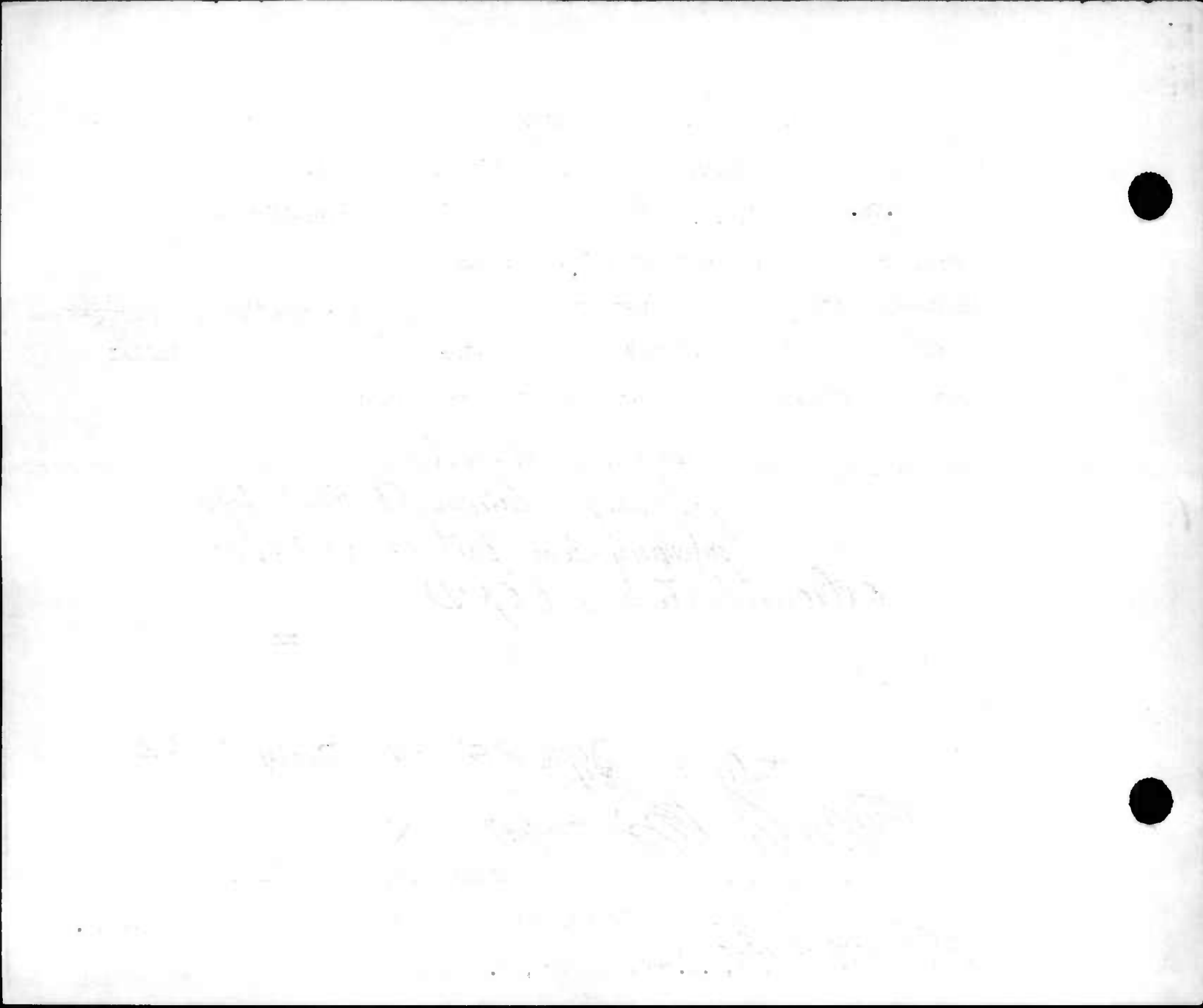
1. DECEASED NAME (TYPE OR PRINT) John H. Newcomb			2a. DATE OF DEATH MONTH DAY YEAR 7 1 84			2b. HOUR 7:05P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 23 38		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME RAY		15. MOTHER'S MAIDEN NAME ELLA KELLEY		13e. STREET ADDRESS / ZIP CODE P.O. Box 114 21562			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. KOREAN 213-24-6344		17. INFORMANT SHIRLEY NEWCOMB			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pulmonary embolism, congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>pulmonary edema, post M.I., post CVD</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>osteoarthritis, COPD</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 25, 1984</i> to <i>July 1, 1984</i> , that (I) (we) last saw the deceased alive on <i>July 1, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Shin E. Kim</i>				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shin E. Kim, M.D.				22e. ADDRESS Westernport, MD 21562			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/4/84		23c. NAME OF CEMETERY OR CREMATORY BLOOMINGTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BLOOMINGTON ALLEGANY MD.	
24. FUNERAL HOME OR PERSON <i>Boals' Funeral Service, P.A.</i>				25a. DATE REC'D. BY REGISTRAR JUL 10 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Mary Northcraft			2a. DATE OF DEATH MONTH DAY YEAR July 31, 1984		2b. HOUR 12:40 P. M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 908 Harding Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ---Housewife---		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Henry Shultz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harrietta Iola Barr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 286-09-2151B		17. INFORMANT ADDRESS Albert Northcraft 908 Harding Ave. Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA Tuberc DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE George Breza MD DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Breza, M.D.				22e. ADDRESS Braddock Medical Gp. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.		
24. FUNERAL DIRECTOR NAME Silcox-Merriitt Funeral Ser. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR AUG 6 - 1984				
				25b. REGISTRAR'S SIGNATURE Julia Fardian-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

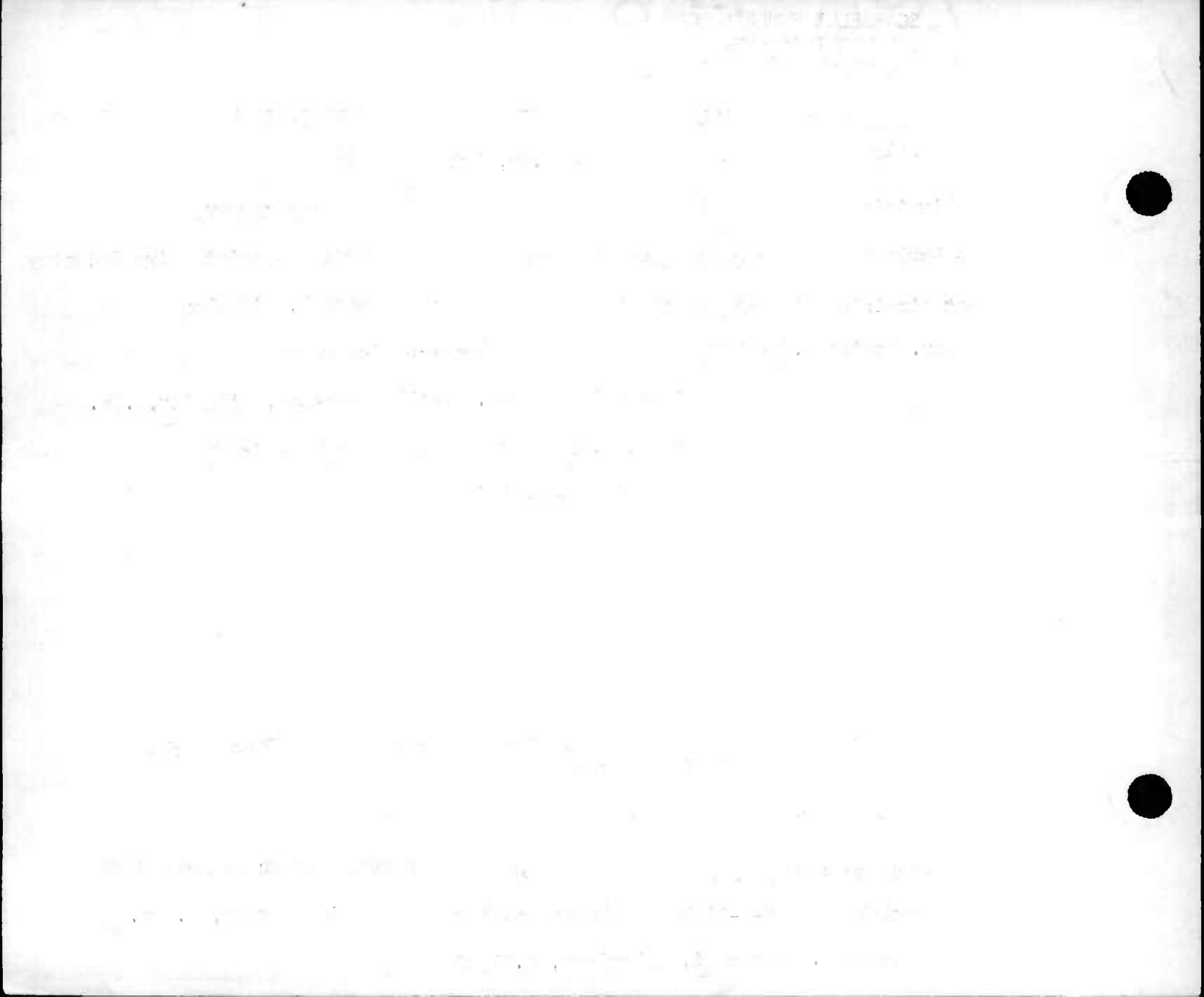
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

SCARPELLI FUNERAL HOME				STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 4 1 7 1 8 9					
1. FOR STATE REGISTRAR 108 VIRGINIA AVENUE CUMBERLAND, MD 21502				CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JOHN WILLIAM PARKER				JULY 3, 1984								2:30A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Jan. 20, 1910		74		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				ALLEGANY COUNTY, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		SACRED HEART HOSPITAL		Retired Chemist		Tire Industry							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
West Virginia				Mineral		Ridgeley		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Ridgeley		99999	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Rev. Newton A. Parker				Leonard Dickerson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				214-05-4139		Mrs. Lucille Brenaman, Ridgeley, W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a)		MASSIVE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		C.A.D.							
				(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-29 1984 to 7-3 1984, that (I) (we) last saw the deceased alive on 7-2 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
URIEL VELANDIA, M.D.				924 SETON DRIVE, CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				7-6-1984		Lebanon Cemetery		Sinks Grove, W. Va.					
24. FUNERAL DIRECTOR NAME				25. DATE RECEIVED BY BURIAL									
James F. Scarpelli, Cumberland, Md. 21502				JUL 9 1984									

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(MVA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

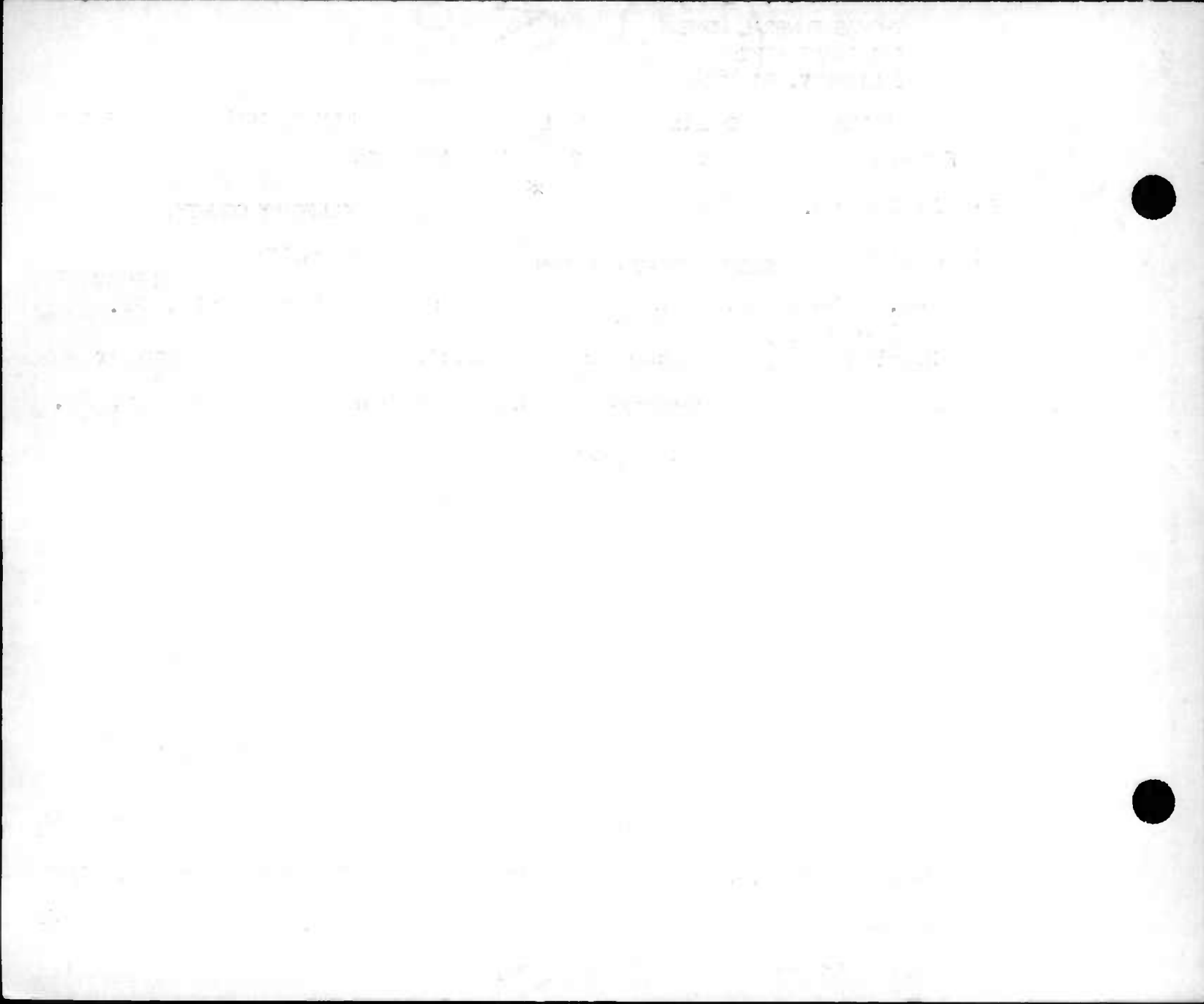
IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

THOMAS FUNERAL HOME 1- STATE REGISTRAR 101 GRANT STREET SALISBURY, PA 15558				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 84 17790			
1. DECEASED NAME (TYPE OR PRINT) MELDA CORDIE PAUL				2a. DATE OF DEATH MONTH DAY YEAR JULY 8, 1984				2b. HOUR 5:20P M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7 MONTH 29 DAY 14 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Summit Twp Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Pa.		13b. COUNTY Somerset		13c. CITY OR TOWN Greenville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD3 Meyersdale, Pa. 15552			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Schafer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Sanner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 185267784		17. INFORMANT George W Paul				ADDRESS RD3 Meyersdale, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acc of breast with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-8-84</u> to <u>7-8-84</u> , that (I) (we) lost saw the deceased alive on <u>7-8-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE <u>John Mehan</u>				DEGREE M.D.				22c. DATE SIGNED 7-9-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.				22e. ADDRESS 909 B SETON DRIVE, CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-11-84		23c. NAME OF CEMETERY OR CREMATORY GRANVILLE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE GREENVILLE TWP - SOMERSET - PA.					
24. FUNERAL DIRECTOR NAME GARFIELD F THOMAS - GRANT ST. SALISBURY, PA				25a. DATE REC'D. BY REGISTRAR JUL 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

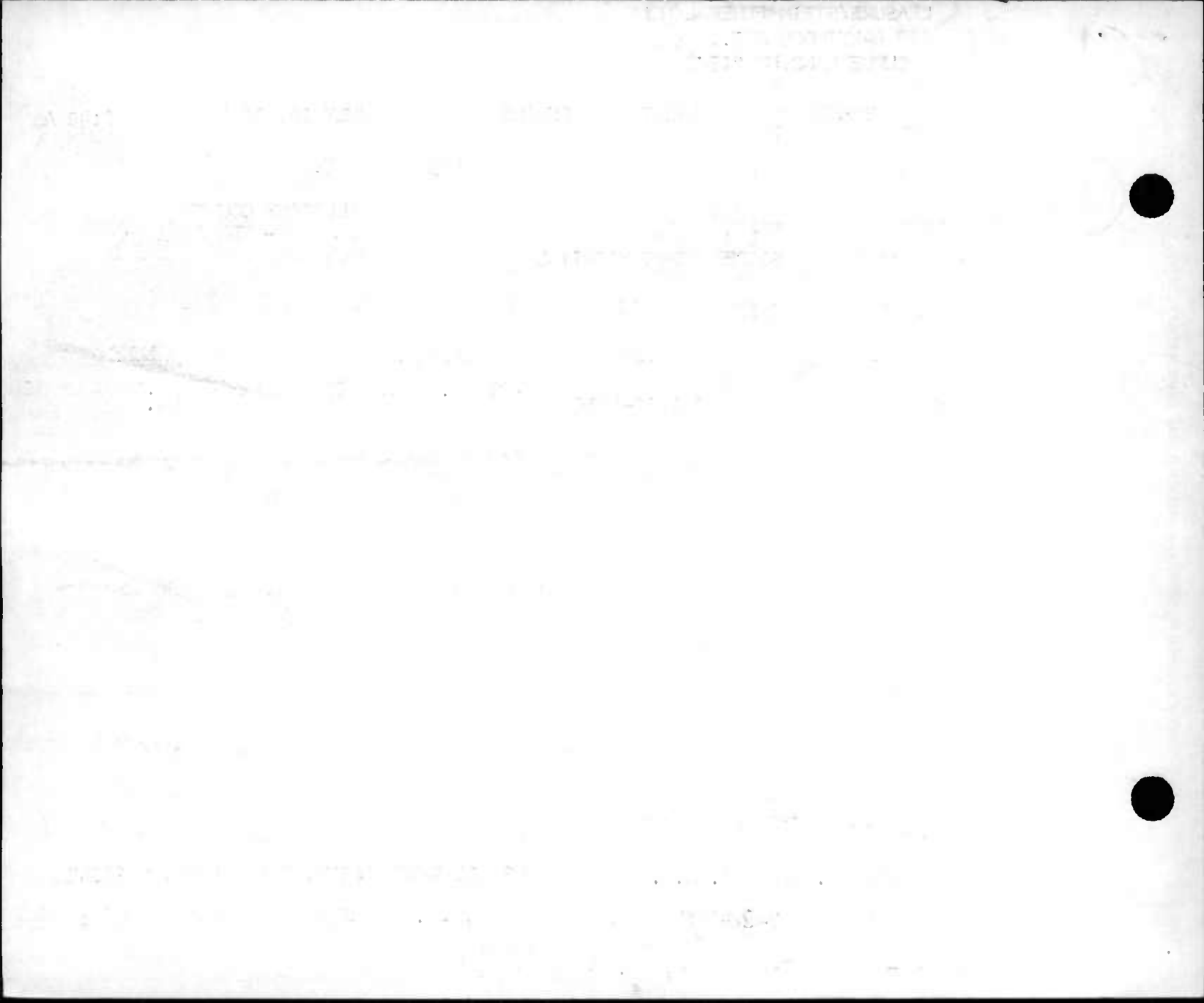
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

LEASURE-STEIN FUNERAL HOME				STATE OF MARYLAND			
FOR 230 BALTIMORE AVE., STATE REGISTRAR CUMBERLAND, MD 21502				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
EDWARD ELBERT PFRANG				JULY 16, 1984			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		MONTH DAY YEAR		70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
NEW YORK		U S A				ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. US OCCUPATIONAL KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL				RET, SUPERVISOR A B L	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		ALLEGANY		CRESAPTOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
EDWARD PFRANG				KATHERINE BLUME			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		157-12-4910		MARIE D. PFRANG 130 BELAIR DRIVE. CRESAPTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u>							2 1/2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral aneurysm of edon</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>ASCVD = Coronary Artery Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>84</u> , to <u>July 16</u> , 19 <u>84</u> , that (I) (we) lost <u>below: (I) (we) don't (did not) see the body after death.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>Wayne M. Spiggle, M.D.</u>				<u>W</u>		7/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
WAYNE M. SPIGGLE, M.D.				BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		7-20-1984		GEO WASHINGTON MEM. PK		PARAMUS BERGEN NEW JERSEY	
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS				25c. DATE REC'D BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
LEASURE-STEIN FUNERAL HOME, INC. CUMBERLAND, MD 21502				JUL 24 1984		Julia Davidson-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Nellie NMI Porter						2a. DATE OF DEATH MONTH DAY YEAR July 20, 1984			2b. HOUR 7:03a_M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 30, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 3, Box 436				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Greenhouse			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 436 21532			
14. FATHER'S NAME FIRST MIDDLE LAST James Mc Farland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-32-8056B		17. INFORMANT ADDRESS Russell H. Porter, Eckhart, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week	
DUE TO, OR AS A CONSEQUENCE OF (b) H.C.V.D.										—	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) arterio-sclerosis										—	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Senile dementia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (his hospital) attended the deceased from 6-10 , 19 84 , to 7-20 , 19 84 , that (I) (we) lost saw the deceased alive on 7-19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H.C. Diehl, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-10-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. C. Diehl, M.D.						22e. ADDRESS 95 E. Main St., Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 22 '84		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eckhart, Allegany, Md.					
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.						25a. DATE REC'D. BY REGISTRAR JUL 25 1984		25b. REGISTRAR John Davidson			

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Page 154

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SECRET VLADEIA DIA(VLADEIA)

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214-35-80708 Russell H. Porter, Richard H. Porter, No.

U.S. AIR FORCE, WASHINGTON, D.C.

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Direct Financial Data, 1960-1969

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 7 9 3

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER FRANK PURKEY			2a DATE OF DEATH MONTH DAY YEAR JULY 2, 1984			2b HOUR 2:05 P. M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Engineer		12b KIND OF BUSINESS OR INDUSTRY Railroad	
13a STATE W. Va.				13b COUNTY Mineral		13c CITY OR TOWN Ridgeley	
14 FATHER'S NAME FIRST MIDDLE LAST George P. Purkey				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gettie Vance			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-2119		17 INFORMANT ADDRESS Mrs. Daphene Purkey, Ridgeley, W.Va. Wife			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Stem Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>GI Bleeding, COPD, CHF</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from <u>6/25/84</u> , to <u>7/2/84</u> , that (I) (we) last saw the deceased alive on <u>7/2/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Shawn A. Miller</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>7/3/84</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. NATHAN				MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-5-1984		23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR NAME James F. Scarpelli				25a DATE REC'D. BY REGISTRAR JUL 9 1984			

BP

DHMH-16 25M
VRA 15-4 1/78

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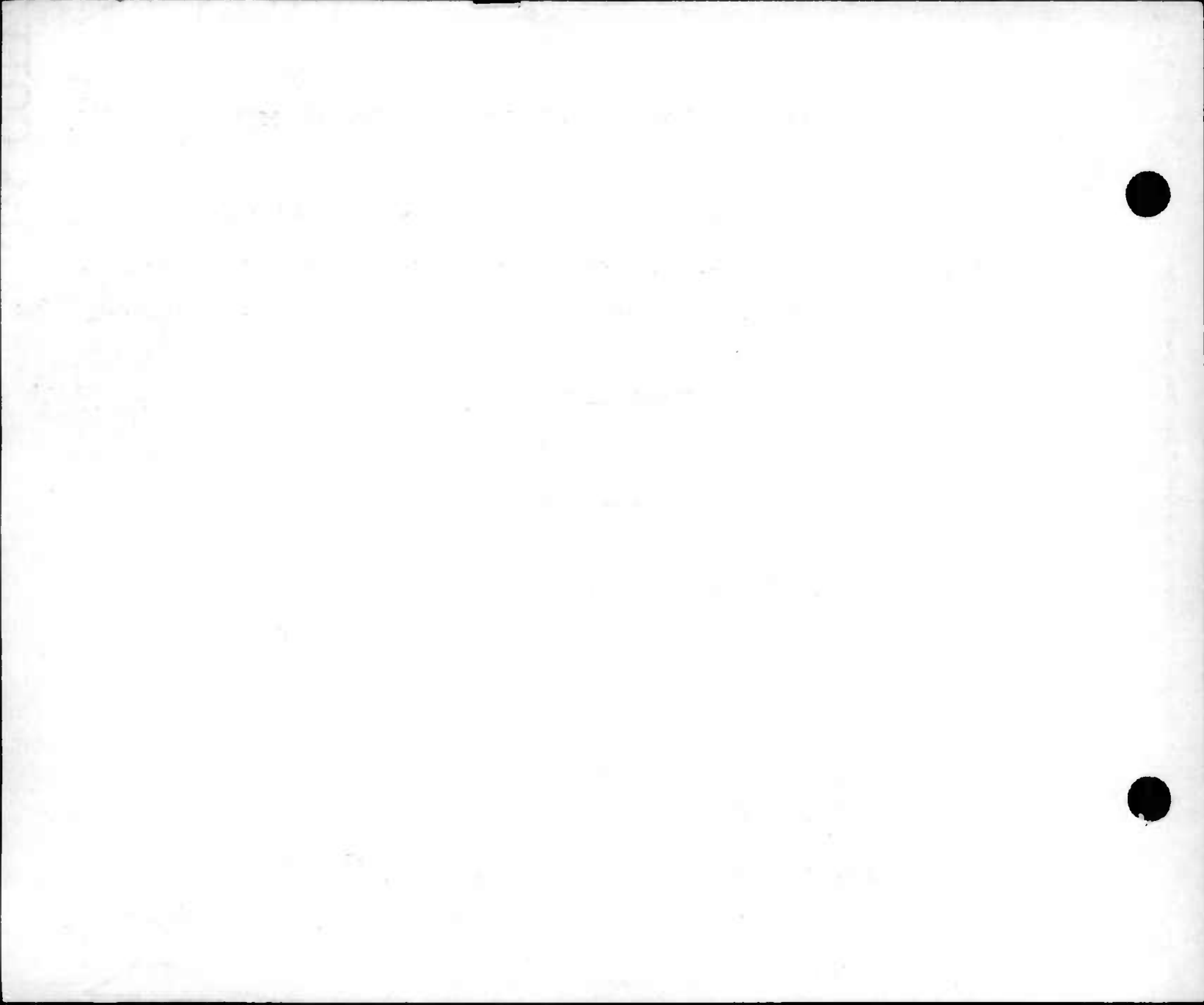
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA CARLON ROBINETTE			2a. DATE OF DEATH MONTH DAY YEAR JULY 12, 1984		2b. HOUR MIN. SEC. 1:20 P.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 10 1901		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper----		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Geary		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma O. Roby		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-05-5181	
17. INFORMANT ADDRESS Sykesville, MD 21784		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) ----		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: per 1 attachment	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-11 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 955 Frederick St. Cumberland, Maryland 21502		22a. I certify that (1) this hospital attended the deceased from 7-8 84 to 7-12 84 that (2) (we) lost saw the deceased alive on 7-11 84 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) did not view the body after death		22b. SIGNATURE Dr. Anthony J. Bollino	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED 7-12-84		22f. PHYSICIAN'S SIGNATURE Dr. Anthony J. Bollino	
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 7-15-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Savage U. Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS Silcox-Merritt F.H. 404 Decatur St., Cumb. MD 21502		25a. DATE REC'D. BY REGISTRAR 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodale		25c. REGISTRAR'S NAME Julia Davidson-Rodale	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Randolph	MIDDLE Charles	LAST Rupp, Jr.	2a. DATE KNOWN OF DEATH	XX 7-23 19 84	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 - 20 - 65	6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	XX 7-23 19 84	2d. HOUR 5:27 n M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.						
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Works-Under		12b. KIND OF BUSINESS OR INDUSTRY CETA Program			
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 118 Hanover St. / 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Randolph Charles Rupp, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally A. Keithline						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Sally Oyer		Rt. #8 ADDRESS Box #184, Neill Rd. Cumberland, Maryland 21502			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:40 M. 7-24 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 118 Hanover St., Cumberland, Allegany Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Dennis F Smyth, M.D.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 7-24-84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/26/84		23c. NAME OF CEMETERY OR CREMATORY Yellow Creek Reform Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hopewell, Pennsylvania			
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502		25a. DATE REC'D BY REGISTRAR JUL 30 1984		25b. REGISTRAR'S SIGNATURE [Signature]					



RECEIVED

W. A. M. N.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Karen Sue Shaffer		7 16 19 84		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	12 16 60 23	YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.	WIDOWED	DIVORCED	Allegany County	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Savage	Dutch Hollow Road Rt. 1 Box 71	Housewife	Own Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Allegany	Mt. Savage	YES NO	Rt. 1 Box 71	21545
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Harry E. Merrbach Sr.	Nancy L. Felker	218-96-1092			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?	17b. INFORMANT	17c. ADDRESS			
No	Richard W. Shaffer	see 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiomyopathy					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES NO			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED			
	HOUR A.M. MONTH DAY YEAR	ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2			
21d. INJURY OCCURRED WHILE AT WORK	21e. PLACE OF INJURY	21f. LOCATION			
NOT WHILE AT WORK	(AT HOME, STREET, FACTORY, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held on					
Autopsy XX Inspection Inquiry and in my opinion					
death resulted from: Natural cause X Accident Suicide Homicide Undetermined manner					
ACTUAL SIGNATURE					
TITLE (SPECIFY) Deputy Chief					
MEDICAL EXAMINER					
DATE SIGNED 7/17/84					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, MD.					
ADDRESS 111 Penn St. Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	7/20/84	Methodist Cemetery	Mt. Savage	Allegany	Md.
24. FUNERAL DIRECTOR					
NAME 57 Frost Ave.					
Durst Funeral Home Frostburg, Md 21532					
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
JUL 25 1984 Julia Davidson-Rendell					

STATE OF MARYLAND
DEPARTMENT OF SOCIAL SERVICES
FACILITY EVALUATION

Female White 12' 60 23

X

Maryland U.S.A.

Own home Housewife Mt. 1 box 11

Maryland Allegany Mt. Savage X St. 1 box 11

Harry E. Kernbach Sr. Harry D. Baker

no 218-98-1025 Richard A. Shaller see 13a

218-98-1025

CR 3217

First funeral home, Rossburg, Md. 218-98-1025
Methodist cemetery Mt. Savage Allegany, Md.
218-98-1025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 3417191	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine E. Sine			2a. DATE OF DEATH MONTH DAY YEAR July 10, 1984		2b. HOUR 7:35 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 11, 1911		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 72 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cresaptown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14805 Connecticut Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N.		12b. KIND OF BUSINESS OR INDUSTRY Hospital
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cresaptown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 14805 Connecticut St. / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST John — Mc Grougan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna — Fournier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 232-50-4158		17. INFORMANT ADDRESS John C. Sine - Address same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER - LARGE CELL/MS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>COPD CH, VENT. PROBLEMS</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>83</u> , to <u>July 20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.					
22b. SIGNATURE <u>B. D. Behounek</u>		DEGREE M.D.		22c. DATE SIGNED 7/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce D. Behounek, M.D.		22e. ADDRESS 912 Seton Drive - Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-13-84		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem'l. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg - Allegany Co - Md.					
24. FUNERAL DIRECTOR NAME George - Upchurch Funeral Home, P.A.		25a. DATE REC'D. BY REGISTRAR JUL 30 1984		25b. REGISTRAR'S SIGNATURE Julia Harrison-Watson	
26. ADDRESS 262 Greene St. - Cumberland, Md. 21502					

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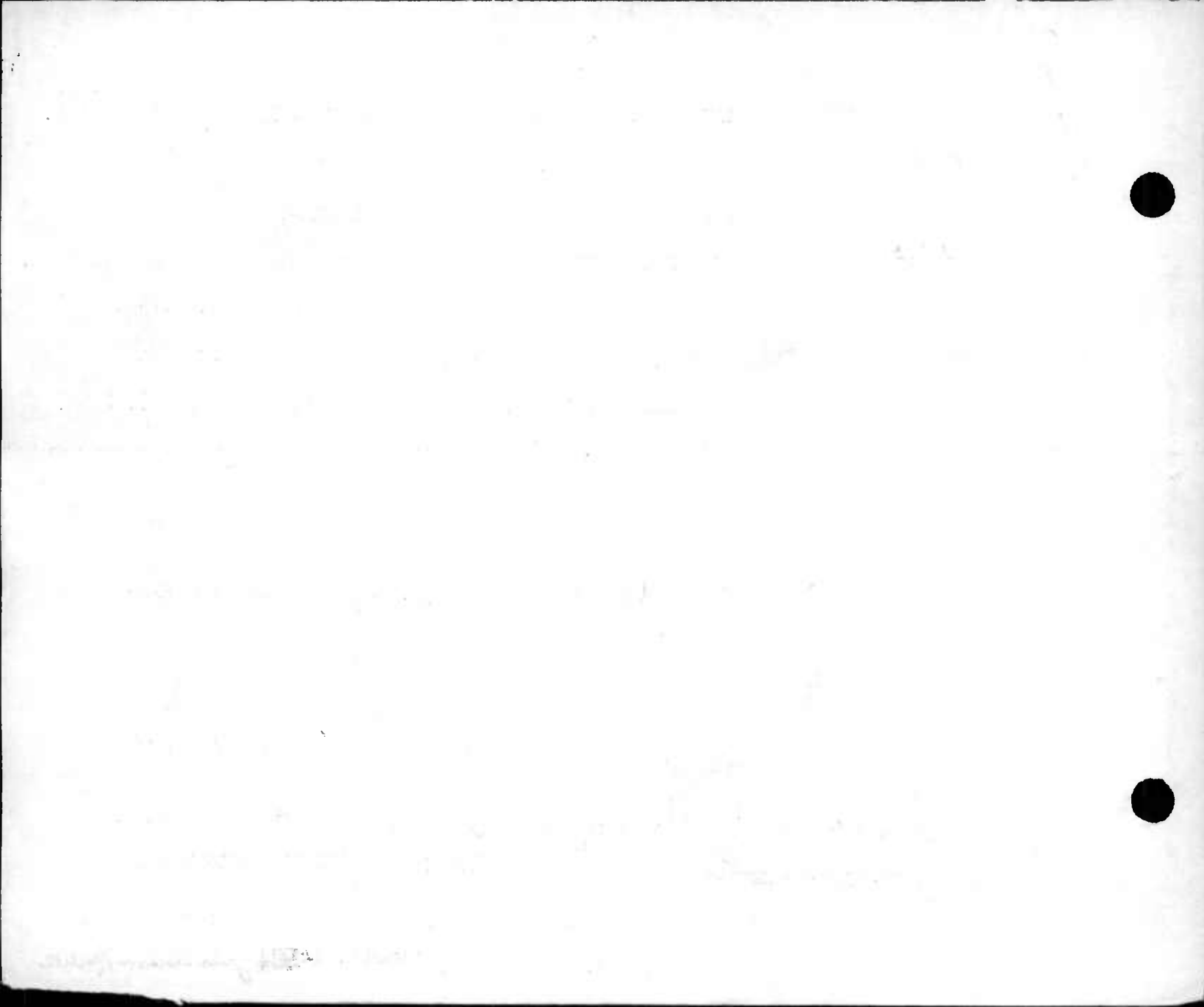
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					8 4 1 7 7 9 8						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY CATHERINE SINES					2a. DATE OF DEATH MONTH DAY YEAR JULY 4, 1984				2b. HOUR 7:43 P.M.		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR DEC. 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Mattress Fact.			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 810 Sunbury Ave. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Wiegand				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hermania Schultz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-26-9976		17. INFORMANT ADDRESS Joseph Kenney 212 S. Allegany St., Cumb. Md. 21502							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. 1a <u>Urinary Tract Infection, Congestive Heart Failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-4-84</u> to <u>7-4-84</u> , that (I) (we) last saw the deceased alive on <u>7-4-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robustiano J. Barrera, Jr. MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-5-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO BARRERA				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/84		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.					
24. FUNERAL DIRECTOR NAME George-Upchurch Fun'l. Home, P.A. 202 Greene St. Cumberland Md. 21502						25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE JUL 11 1984 Julia Gordon-Randall					

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HAFER FUNERAL HOME

STATE OF MARYLAND

1. FOR STATE REGISTRATION
1302 NATIONAL HIGHWAY
LAVALE, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HYACINTH BERTHA SKELLY			2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1984		2b. HOUR 5:40P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 29 02	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee		12b. KIND OF BUSINESS OR INDUSTRY Fiber
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cresaptown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph N. Skelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-52-1574		17. INFORMANT ADDRESS Freda Skelly - same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD, treated pulm.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pace maker recent.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1984</u> to <u>July 18, 1984</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Shin Kim, M.D.</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHIN KIM, M.D.				22e. ADDRESS 90 MAIN STREET, WESTERNPORT, MD 21562	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/21/84	23c. NAME OF CEMETERY OR CREMATORY St. Ambrose Ceme. Cresaptown, Alleg., MD		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.			25a. DATE REC'D. BY REGISTRAR JUL 23 1984		
ADDRESS LaVale, MD			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>		

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#16, 11mG598 12/10/84 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
SCARPELLI FUNERAL HOME
108 VIRGINIA AVENUE
CUMBERLAND, MD. 21502
REGISTRAR
8 4 1 7 6 0 0
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY LOUISE SMITH			2a. DATE OF DEATH MONTH DAY YEAR JULY 22, 1984			2b. HOUR 9:45A M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-10-26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE WV COUNTY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 2 Box 474E 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Mullan, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Bishop					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no		16b. SOCIAL SECURITY NO. 218-16-4523 215-20-6463		17. INFORMANT ADDRESS William G. Smith, Sr., Ridgeley, WV					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Liver Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 22, 1984, to July 22, 1984, that (I) (we) last saw the deceased alive on July 22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. BRUCE BEHOUNEK, M.D.								22c. DATE SIGNED JUL 27 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
DR. BRUCE BEHOUNEK, M.D.				BMG, 912 SETON DR., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07-24-84		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR JUL 27 1984					
				25b. REGISTRAR'S SIGNATURE Julia Davidson					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Elizabeth Smith					2a. DATE OF DEATH MONTH DAY YEAR July 25 1984					2b. HOUR 7:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12 1892		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 635 Washington Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 635 Washington Street 21502		
14. FATHER'S NAME FIRST MIDDLE LAST James H. White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Elbin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-3024		17. INFORMANT Liberty Trust Bank Cumberland				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line, or two, if not linked.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple strokes - CVA 4 years DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from above (1) (we) (did) (did not) view the body after death. 19 72 1984 that (I) (we) lost											
22b. SIGNATURE Dr. Guy Fiscus						DEGREE MD		22c. DATE SIGNED 7/26		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus					22f. ADDRESS Memorial Hospital Medical Building						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07/28/84		23c. NAME OF CEMETERY OR CREMATORY Rosehill Mausoleum			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME Silcox-Merritt F.H.					ADDRESS 404 Decatur St., Cumb., MD		25a. DATE REC'D. BY REGISTRAR JUL 30 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

Handwritten notes and a large, faint diagram or sketch, possibly a map or a technical drawing, covering the majority of the page. The text is mostly illegible due to fading and bleed-through from the reverse side.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SCARPELLI FUNERAL HOME				STATE OF MARYLAND	
1. FOR STATE REGISTRAR 108 VIRGINIA AVENUE CUMBERLAND, MD. 21502				DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CUMBERLAND, MD. 21502				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
WILLIAM A. SOWERS, SR.				JULY 6, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		white		02-13-98	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
WV		USA		86	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland		SACRED HEART HOSPITAL		ALLEGANY COUNTY, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
retired		railroad		Queen City Towers 21502	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Allegany		Cumberland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
William Sowers		Alice Drish		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
705-12-4724		Mrs. Mary Smith Hagerstown, MD - daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Pulmonary embolus.</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>and Chronic myelocytic Leukemic.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>84</u> , to <u>7-6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7-6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
DEGREE					
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
URIEL VELANDIA M.D.				924 SETON DRIVE CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		07-09-84		Davis Memorial Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Cumberland Allegany MD		JUL 11 1984			
24. FUNERAL DIRECTOR NAME				25a. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, MD 21502				Julian Davidson	

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1947-1948
1949-1950
1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOALS FUNERAL HOME 1- STATE REGISTRAR 111 CHURCH ST. WESTERNPORT, MD.				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 7 3 0 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ROBERTA MARIE STAFFORD				2a. DATE OF DEATH MONTH DAY YEAR JULY 29, 1984				2b. HOUR 3:30P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 15 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Westvaco			
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Luke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Milton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evylyn Marie Penford				12. STREET ADDRESS / ZIP CODE 500 Grant St. Luke, Md. 21540			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220076093		17. INFORMANT ADDRESS Mr. Fred Phelps Whiteford, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 months years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1983</u> to <u>July 29 1984</u> , that (I) (we) lost saw the deceased alive on <u>July 29 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>Aug 1 '84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BMG				22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21520							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/84		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery				23d. LOCATION Westernport, Allegany Md. STATE			
24. FUNERAL DIRECTOR Boals Funeral Service				ADDRESS Westernport, Md.				25a. DATE REC'D. BY REGISTRAR 2133 6 - 1984			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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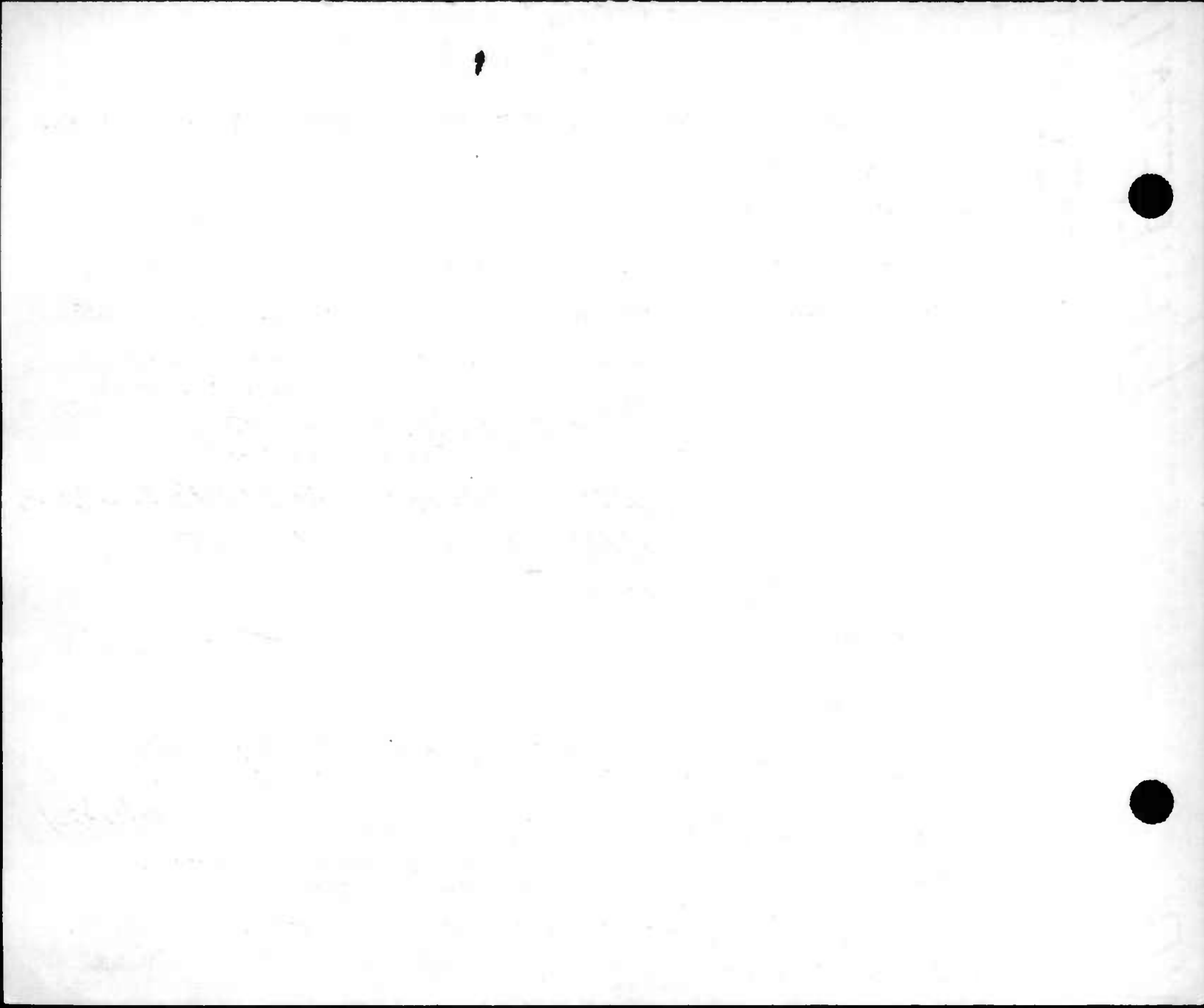
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2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GUY STEWART STANTON, SR						2a. DATE OF DEATH MONTH DAY YEAR July 7, 1984		2b. HOUR 1:08a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 29, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Route, Box 15 21536			
14. FATHER'S NAME FIRST MIDDLE LAST William T. Stanton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mary Durst		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 1							
16b. SOCIAL SECURITY NO. 220-34-1363		17. INFORMANT ADDRESS Star Route, Box 15 Almira T. Stanton, Grantsville, MD 21536									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEIZURES AND RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRONCHITIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) COR PULMONALE -											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) this hospital attended the deceased from 7/6/84 to 7/7/84, that (b) (we) last saw the deceased alive on 7/6/84 and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) sign the body after death.											
22b. SIGNATURE Dr. James Raver		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/7/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, Md.					
24. FUNERAL DIRECTOR A. Lynn Newman		ADDRESS Grantsville, MD		25. DATE RECEIVED BY REGISTRAR JUL 13 1984		REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Virginia Summers			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1984			2b. HOUR 07:15p_M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 23, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Textile		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 130 Mullin Street 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Garfield Appel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Hobday							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-7870		17. INFORMANT ADDRESS Lions Manor Nursing Home, Seton Dr., Cumberland, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of brain DUE TO, OR AS A CONSEQUENCE OF (c) Primary Carcinoma of the lungs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —									APPROXIMATE BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/7 , 19 84 , to 7-6 , 19 84 , that (I) (we) lost saw the deceased alive on 7-6-84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE V. A. Ranjithan.			DEGREE V. A. Ranjithan.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-7-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vimala Ranjithan, M.D.			22e. ADDRESS Lions Manor Nursing Home, Seton Dr. Cumberland,							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07-09-84		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502			25a. DATE REC'D. BY REGISTRAR JUL 11 1984			25b. REGISTRAR'S SIGNATURE Julian Davidson-Randall				

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RECEIVED
JUL 11 1962
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

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MEDICAL CERTIFICATION

DURST FUNERAL HOME				STATE OF MARYLAND			
1. STATE 57 FROST AVENUE				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
FROSTBURG, MD. 21532				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
HELEN GERTRUDE THARP				JULY 15, 1984			
3. SEX				4. RACE			
Female				White			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
August 14, 1909				74			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Cumberland				ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Cleaning				Factory			
13a. STATE				13b. COUNTY			
Maryland				Allegany			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Frostburg				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
William Folk				Edith Bowser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
No				214-62-4152			
17. INFORMANT				ADDRESS			
Mrs. Edna Yutzy, Rt. 2, Frostburg, Md.				21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Congestive Heart Failure							
DUE TO, OR AS A CONSEQUENCE OF (b) ASVD							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from July 15, 1984, to July 15, 1984, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
DR. WAYNE SPIGGLE				July 16 '84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
				BMG, 912 SETON DRIVE, CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7/18/1984		Frostburg Mem. Pk.		Frostburg, Allegany Md.	
24. FUNERAL DIRECTOR							
NAME Durst Funeral Home, Frostburg, Md. ADDRESS							
25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
JUL 23 1984 Julie Davidson-Randall							

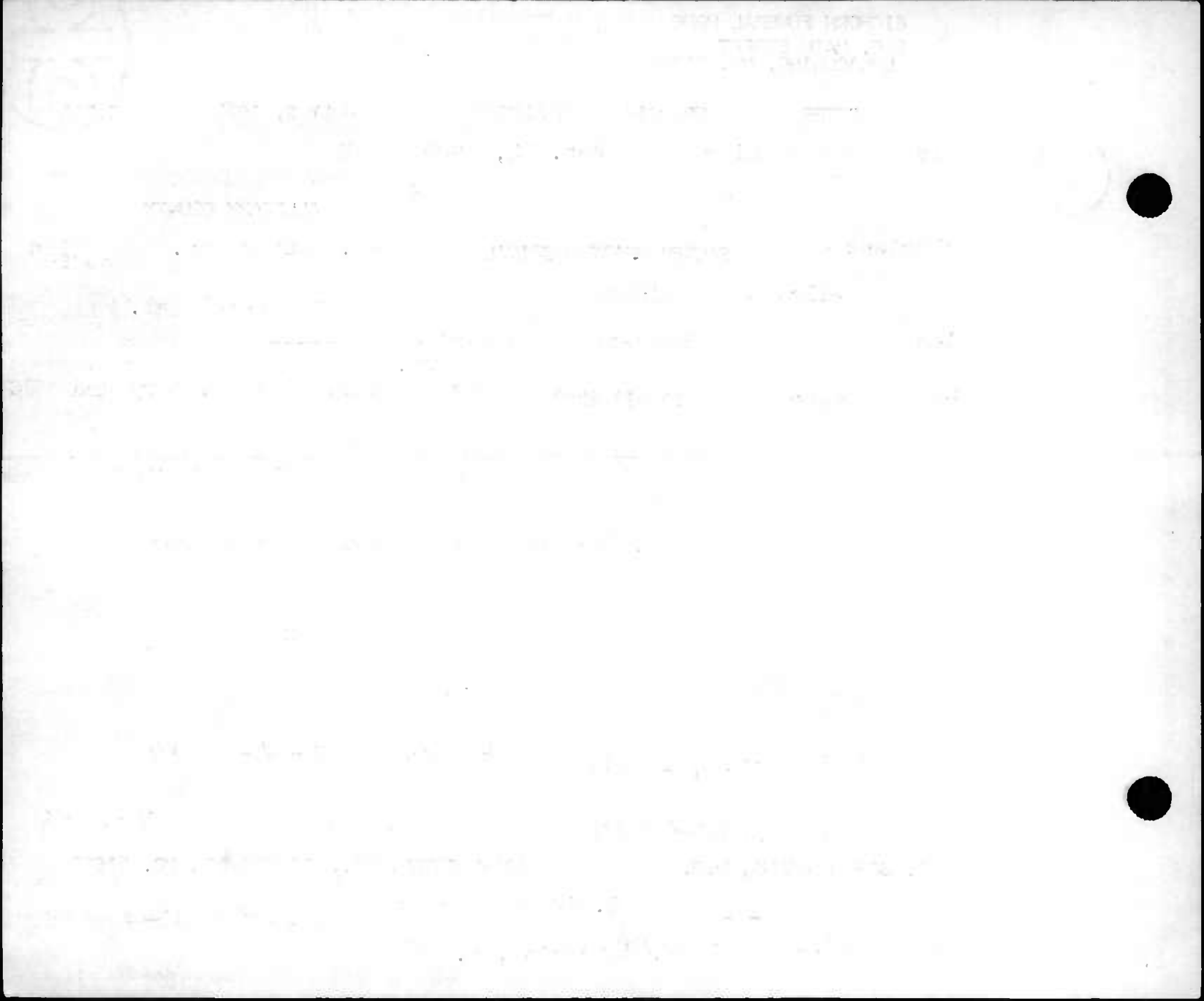
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

EICHORN FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
8 E. MAIN STREET LONA CONING, MD. 21539				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
PETER FRANCIS THOMPSON				JULY 2, 1984			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
Male		White		Feb. 22, 1909		75	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md		USA		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Ret. County Emp.		Election Board	
13a. USUAL RESIDENCE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md		Allegany		Midland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE		13f. STREET ADDRESS / ZIP CODE	
Myles		Thompson		Catherine		Box 21 General Del. 21542	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		212-12-8228		Mrs. Florence Blair, Midland, Maryland		21542	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Intractable Rt Heart Failure</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long Willebrand's disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-12-1984</u> to <u>7-2-1984</u> , that (I) (we) lost							
saw the deceased alive on <u>7-1-1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>John Mehanua</u>				M.D.		7-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
DR. JOHN MEHANUA, M.D.				909-B SETON, DR., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7-4-84		St. Michaels Cemetery		Frostburg Allegany Md	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Guy A. Eichhorn</u>				JUL 4 5 1984		<u>John Mehanua</u>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William C. Twigg										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 29 84		2b. HOUR P M 11:23 P M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-07-07		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 77		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 29 84		11:23 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany Co. MD.			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Textile			
13a. STATE WV				13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1 Box 192A			
14. FATHER'S NAME FIRST MIDDLE LAST William C. Twigg Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Louise Minnick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217-10-6358		17. INFORMANT ADDRESS Mary Twigg, Ridgeley, WV - wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <u>Giovanni Mastrangelo</u>				TITLE (SPECIFY) <u>M.D.</u>				MEDICAL EXAMINER				DATE SIGNED <u>7/30/84</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Giovanni Mastrangelo, M.D.</u>				ADDRESS <u>Cumberland, MD 21502</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>08-01-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Ft. Ashby</u> COUNTY <u>Mineral</u> STATE <u>WV</u>					
24. FUNERAL DIRECTOR NAME <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, MD 21502</u>				25a. DATE REC'D. BY REGISTRAR <u>2-1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			



Department of Education

Division of Adult Education

Division of Adult Education, U.S. Department of Education, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 1 7 8 1 0			
SILCOX/MERRITT FUNERAL HOME 404 DECATOR STREET CUMBERLAND, MD 21502				CERTIFICATE OF DEATH			
FOR 1- STATE REGISTRATION				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRA CECILIA VANDERHOUT				2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1984			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 11 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 631 HENDERSON AVE. 21502			
14. FATHER'S NAME FIRST MIDDLE LAST ROSS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ETTA HEMING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-0788		17. INFORMANT ADDRESS ROBERT VANDERHOUT WILMINGTON, DEL 19810 3125 WILMONT DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 14, 1984</u> to <u>July 14, 1984</u> , that (I) (we) lost saw the deceased alive on <u>July 14, 1984</u> and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Wayne Spiggle</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 15, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WAYNE SPIGGLE				22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 17 1984		23c. NAME OF CEMETERY OR CREMATORY SSPETER & PAUL CEMETERY		23d. LOCATION CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD				25a. DATE REC'D. BY REGISTRAR JUL 17 1984			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

BOAL FUNERAL HOME 111 CHURCH STREET WESTERNPORT, MD 21532				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ELIZA MAY WARNICK				2a. DATE OF DEATH JUNE 28, 1984		2b. HOUR 12:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec 7 1996		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Harry MIDDLE M. LAST Foreman		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE M. LAST Ott		13e. STREET ADDRESS / ZIP CODE Md. Ave Westernport Md. 21562			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-48-4248		17. INFORMANT H. Fred Warnick Md. Ave. Westernport Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Constrictive Pant Girdle, Ca. of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac, CAD (angina) pectoris</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>84</u> , to <u>June 28</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>June 28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Shin Kim</u>				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHIN KIM, MD				22e. ADDRESS 90 MAIN STREET, WESTERNPORT, MD 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/30/84		23c. NAME OF CEMETERY OR CREMATORY Philos Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.	
24. FUNERAL DIRECTOR NAME Boal Funeral Service Westernport Md.				25. DATE RECEIVED BY REGISTRAR JUL 9 1984			

MEDICAL CERTIFICATION

[The body of the page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs, with some lines appearing as bulleted lists. Due to the low contrast and high noise of the scan, the specific words and sentences cannot be transcribed.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked as "yes," any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 17812											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE Wilda WATSON						2a. DATE OF DEATH MONTH DAY YEAR 7 27 84				2b. HOUR 0545 A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 20 96		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALEGANY COUNTY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper----		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Flintstone						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural Rt. 21530			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH REED				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anzina Conrad							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-32-6828		17. INFORMANT Blaine Burgess				ADDRESS Flintstone, Md 21530			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pancreatic Cyst.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-31-84, to 7-27-84, that (I) (we) last saw the deceased alive on 1-26-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robustiano J. Barrera, Jr.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-27-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robustiano J. Barrera M.D.				22e. ADDRESS Memorial Hosp. Bldg Cumberland, Md 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 31/84		23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany Maryland					
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumb. Md 21502				ADDRESS 404 Decatur St.		25a. DATE REC'D. BY REGISTRAR JUL 31 1984		25b. REGISTRAR'S SIGNATURE John Davidson			

Handwritten notes at the top of the page, including "1" and "2" in the left margin, and "1" in the center.



Handwritten notes in the middle section of the page, including "28" and "1" in the left margin, and "1" in the center.

Handwritten notes in the lower middle section of the page, including "1" in the left margin, and "1" in the center.

Handwritten notes in the lower section of the page, including "1" in the left margin, and "1" in the center.

Handwritten notes at the bottom of the page, including "1" in the left margin, and "1" in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8417813

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRIETTA R WEAKLEY			2a. DATE OF DEATH MONTH DAY YEAR JULY 29, 1984		2b. HOUR 12:55 P.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 3 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) employee	12b. KIND OF BUSINESS OR INDUSTRY Health Dept.	
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 525 Winifred Road 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest MacKenzie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Brotemarkle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 139-10-9522 218-38-2309		17. INFORMANT ADDRESS Adeline Martz 521 Winifred RD., Cumb., MD 21502		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Rheumatoid Arthritis, severe, with Cardiac Amyloidosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/29/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN		22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME Silcox-merritt F.H.		ADDRESS 404 Decatur St., Cumb., MD 21502		25. DATE OF REGISTRATION AUG 2 1984		

100-100000

(100)



X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) George L. Wellings Jr.						2a. DATE KNOWN OF DEATH ESTIMATED July 16, 1984		2b. HOUR 2am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/14/1910		6. AGE (IN YEARS) (LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			MD.		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOTHING SUCH AS CITY, GIVE STREET ADDRESS) 168 Bowery Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY city			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 168 Bowery St. 21532			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Wellings Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Julianna Woodrow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. 2 213-09-6552		17. INFORMANT ADDRESS Mrs. Alberta Wellings, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory Arrest										Sudden	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease										Years	
DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema										Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Paul Snow</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 7/16/84			
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.				ADDRESS Memorial Hosp., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/19/84		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg, Allegany, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md.											
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 23 1984 <i>John Davidson</i>											

George B. Williams Jr. 10/10/1910 14

Male White 5'8.5" 140 lbs

Maryland 168 Bowery Street

Allegany 168 Bowery St. 21332

George B. Williams Jr. 10/10/1910 14

Maryland 168 Bowery Street

Allegany 168 Bowery St. 21332

George B. Williams Jr. 10/10/1910 14

Maryland 168 Bowery Street

Allegany 168 Bowery St. 21332

George B. Williams Jr. 10/10/1910 14

Maryland 168 Bowery Street

Allegany 168 Bowery St. 21332

George B. Williams Jr. 10/10/1910 14

Maryland 168 Bowery Street

Allegany 168 Bowery St. 21332

George B. Williams Jr. 10/10/1910 14

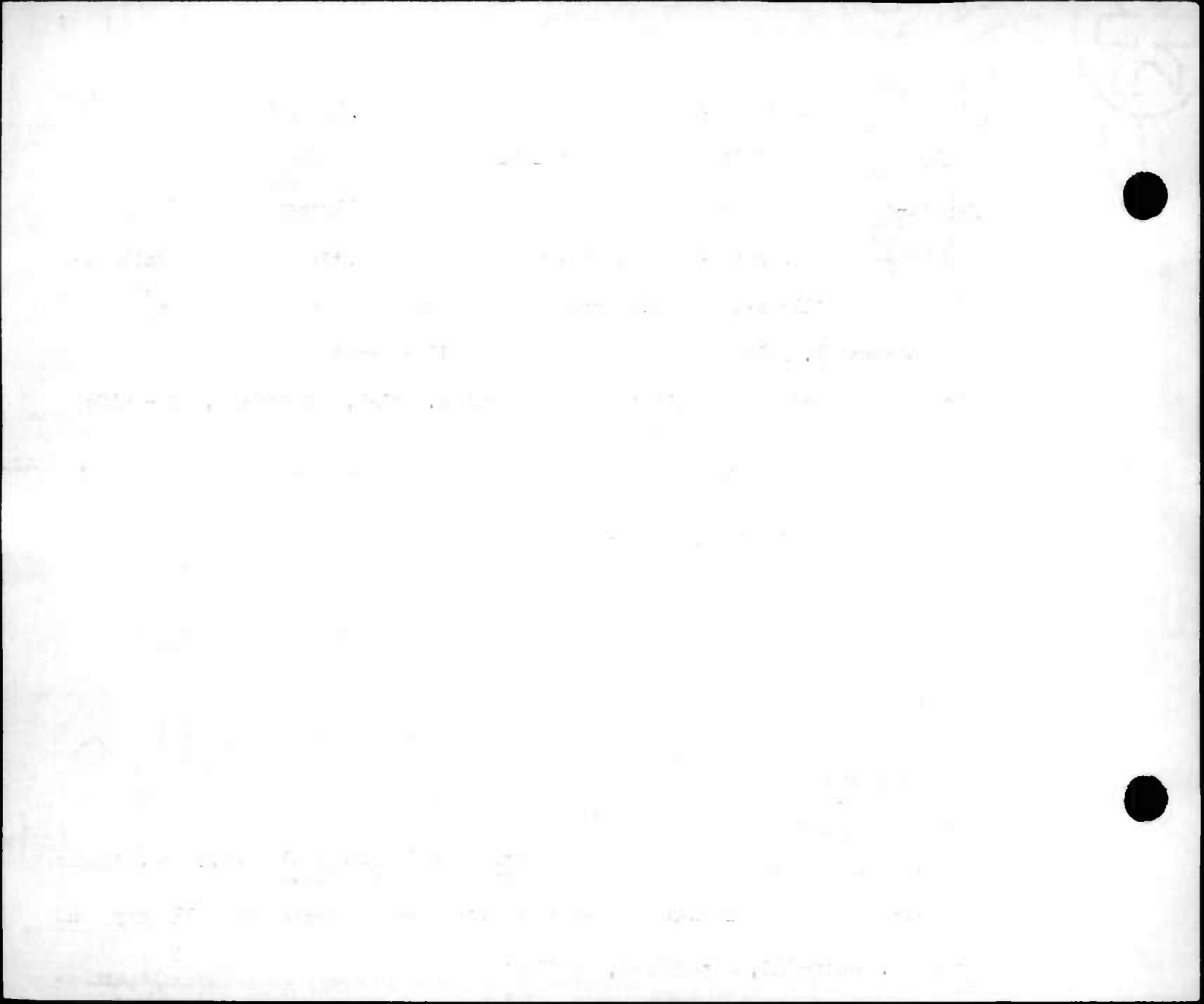
Maryland 168 Bowery Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 8 1 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST WALTER FLOYD WELSH		MONTH DAY YEAR July 5, 1984	
2b. HOUR 1:46 AM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-01-19	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Allegany	
13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Hazen Road 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Emmanuel P. Welsh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Troutman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES War II		16b. SOCIAL SECURITY NO. 214-16-2519	
17. INFORMANT ADDRESS Sarah M. Welsh, Cumberland, MD - wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE OF DEATH Acute myocardial infarction DUE TO OR AS A CONSEQUENCE OF Coronary artery disease DUE TO OR AS A CONSEQUENCE OF Hypertension			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1984 to 1984, that (I) (we) lost saw the deceased alive on 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death			
22b. SIGNATURE W. Guy Fiscus MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. W. Guy Fiscus		22d. ADDRESS Medical Bldg., Memorial Hosp. & Med. Center, Cumberland, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 07-07-84	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JUL 10 1984	
25b. REGISTRAR'S SIGNATURE John Switzer			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7 8 1 6

1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR		7. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		June 29, 1984		7:15 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
FEMALE		white		OCT. 30, 1917	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7. CITIZEN OF WHAT COUNTRY?		8. MARried <input checked="" type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
CUMBERLAND		MEMORIAL HOSPITAL		retired	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
MD		Allegany		Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. STREET ADDRESS	
D. Raymond Alderton		Ella B. Alderton		6 King Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
No		216-14-1086		Basil J. Williams - husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
EXTENSIVE CEREBRO-VASCULAR ACCIDENT					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
DR. QAMAR ZAMAN				MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		07-02-84		Zion Memorial Park	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, MD 21502				9 1984	

EXTENSIVE CEREBRO-VASCULAR
ACCIDENT

5/5/82

① *[Signature]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITHIN 72 HOURS OF DEATH. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Gladys A. Wilson										2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 07 22 1984	
2. SEX Female										2d. DATE PRONOUNCED DEAD 07 22 1984	
3. RACE white										2e. HOUR 3P	
4. DATE OF BIRTH MONTH DAY YEAR 04-19-12										2f. HOUR 9:10P	
5. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.											
6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.											
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD										7. BALTIMORE CITY OR COUNTY OF DEATH Allegany	
7b. CITIZEN OF WHAT COUNTRY? USA											
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH Cumberland										12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Clerk	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 811 Elmwood Lane										12b. KIND OF BUSINESS OR INDUSTRY Postal Serv.	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD											
13b. COUNTY Allegany											
13c. CITY OR TOWN Cumberland										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Newton Shives										13e. STREET ADDRESS 811 Elmwood Lane 21502	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Catherine Shives											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 215-18-8720	
17. INFORMANT ADDRESS Frederick Neff Wilson, Jr. Chantilly, VA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RETROPERITONEAL FIBROSIS SECONDARY TO ANEURYSM											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Paul Snow, M.D.										TITLE (SPECIFY) ASST. DEPUTY	
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.										DATE SIGNED 7/24/84	
ADDRESS Memorial Hospital, Cumberland, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 07-25-84	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.										23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502										25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 27 1984 John Davidson Randall	

01-25-70

12

01-25-70

white

white

Allegory

x

AM

AM

Hotel City

Clark

01-25-70

01-25-70

01-25-70

x

01-25-70

Allegory

AM

01-25-70

01-25-70

01-25-70

01-25-70

AM

01-25-70

01-25-70

01-25-70

01-25-70

01-25-70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

NEWMAN FUNERAL HOME				STATE OF MARYLAND			
1. FOR STATE REGISTRATION				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
PO BOX 267 GRANTSVILLE, MD 21536				8 4 1 7 8 1 8 CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
ALVA ROY YODER				JULY 21, 1984			
3. SEX				4. RACE			
Male				White			
5. DATE OF BIRTH				6. AGE			
MONTH DAY YEAR				(IN YEARS LAST BIRTHDAY)			
Dec. 4, 1908				75			
7a. BIRTHPLACE				7b. CITIZEN OF WHAT COUNTRY?			
(STATE OR FOREIGN COUNTRY)				(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Maryland				USA			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION				12b. KIND OF BUSINESS OR INDUSTRY			
(TYPE OF WORK FOR MOST OF WORKING LIFE)				(TYPE OF WORK FOR MOST OF WORKING LIFE)			
Farmer				Farming			
13a. STATE				13b. COUNTY			
Maryland				Garrett			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Grantsville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE				13f. STREET ADDRESS / ZIP CODE			
Rt. 1, Box 173				21536			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Simon M. Yoder				Catherine J. Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				210090144			
No				Ruth E. Yoder, Grantsville, MD 21536			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Acute Myocardial Infarction</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Coronary Heart Disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
<u>Diabetes mellitus.</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>				21b. TIME OF INJURY			
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR			
(IF EITHER, NOTIFY MEDICAL EXAMINER)				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				21g. LOCATION			
STREET				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
CLARENCE VINCENT, M.D.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
CLARENCE VINCENT, M.D.				909-B SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				July 23, 1984			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Springs Cemetery				Springs, Somerset, Penna.			
24. FUNERAL DIRECTOR				25. DATE REC'D BY REGISTRAR			
A. Lynn Parnaw				JUL 26 1984			
ADDRESS				REGISTRAR'S SIGNATURE			
Grantsville, MD				[Signature]			

BP _____

